Marginalization of first generation immigrant women : an experience with implications for health

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Abstract

The central concern of this research was to examine, from the perspective of first generation immigrant women, the role of the informal sector as a resource for health. The study began by exploring women's perspectives on health and the nature of their relationships within the community as these have been shown to have important protective influences. The theoretical perspective and associated methodology employed was informed by Pierre Bourdieu's logic of practice and Dorothy Smith's institutional ethnography. These theorists accord attention to individuals' experiences, in particular, experiences of those who tend to be overlooked in formal discourse. They provide direction for exploring the power relations that underlie social relations within society and for making manifest the ways these shape experience.

Several forms of data gathered in Britain and Canada were submitted to analysis. Twenty-three women participated in five small group interviews. Thirty-nine follow up interviews were conducted with twenty-two of these women and fifteen of their teenaged daughters. Additional data submitted to analysis included interviews with eight key informants and a review of policy documents.

A central feature of the mothers' and daughters' relationships with others in their new countries was that they were characterized by marginalization. The analysis of the data explores key aspects of the experience and the social conditions that shaped them. The participants' experiences are discussed in relation to the discourses of inequalities in health and culture and health.

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Chapter 1

Background to the Study and Conceptualization of the Problem

In this chapter I introduce this study and illustrate how it builds on earlier research with immigrant women. An overview of the conceptualization of the problem of interest and a justification for the theoretical and methodological approach used in the study is provided. This chapter delineates the starting point of the research. Broadly framed I began with an interest in understanding the role of the informal sector as a resource for health by seeking to understand immigrant women and their teenaged daughters' perspectives on their relationships within the community.

As the title suggests however these relationships were characterized by marginalization or what the women viewed as their marginal status within the community. So, although this chapter introduces the starting point of the research the balance of the thesis takes the reader through the research process as it unfolded. This journey ultimately arrived at a point of exploring whether marginalization is an experience with consequences for health while also considering the role of broader social structures in shaping such experiences. In presenting this work I have sought to illustrate how I took direction from theory in designing and undertaking it. I demonstrate how I drew upon theory to gain an understanding of the experiences of the mothers and daughters who participated in order to produce new insights into, and prompt reflection on, social influences on health.

The Social Contexts in which the Study was Undertaken

Britain and Canada, like a number of other countries world wide, are engaged in a process of health reform (Britain[1] Department of Health (DoH), 1989, 1998d, Feb, 1999ab; 2000a; Canada, 1997a, b; Klein, 1995; Rivett, 1997; Spurgeon, 1998). In both countries the discussion about the direction of reform has resulted in an affirmation of their respective commitments to a universal system of health care. Nonetheless in the 1990s each country embarked upon major restructuring driven in part by a desire to reduce costs. Such restructuring has focused on change at the organizational level and emphasized individual,

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[1] Referencing Conventions: Different conventions are used in referencing government documents. In Britain for example it is customary to refer to government publications using the Department as author. However, as I refer to government departments in two different countries and they refer often to different levels of government, I have chosen to use the country as a prefix to the author when citing national documents. I also follow the convention of introducing all authors of a piece of work the first

family and community responsibilities in the health care enterprise. Some consequences of these restructuring efforts include a shift of illness care to the community, an expectation that communities will participate in setting the health agenda, and recognition that community resources must be developed to support families (Britain, DoH, 1989, 1998d, 1999ab; British Columbia (BC),1992; Canada, 1997a,b; Hardey, 1998; Rivett, 1997). While these efforts are laudable and may enhance the capacity of the formal health care system to design effective health promotion initiatives and enhance efficiencies in the ways illness care is provided, there are some reasons for caution.

In a health policy climate where health services are being restructured, programmes redesigned and priorities reassessed, it is possible that change that accompanies reform may impact some groups to a greater extent than others. It has been shown in other times of health or social reform that advances in one forum may come at the expense of some segments of the population. A policy decision to shift care to the community for example, is based on the assumption that families have the capacity, and can access needed resources, to assume the responsibilities associated with health promotion and illness management. Such an assumption presumes resources (personal, material) are available within the informal sector. This assumption is not necessarily valid for all sectors of the population. In times of change it is therefore prudent to seek input from those who are historically left off of policy consultation agendas and groups who have been identified as having access to fewer resources, particularly those of the informal sector which are often poorly understood or taken for granted. One such group is immigrant women.

Area of Study:

The Interface between the Formal and Informal Sectors of the Health Care System

In 1977 Chrisman observed that in the United States (US) 75% of illness management occurred outside of the formal health care system (Chrisman, 1977). Since that time it has been clearly documented that families, particularly women in families, shoulder the largest responsibilities for caregiving and health promotion usually while also managing competing commitments (see for example, Anderson, 1990; Anderson & Elfert, 1989; Angus, 1994; Bridges & Lynam, 1993; Finch, 1989; Graham, 1984, 1993; Hillier & Scambler, 1997;McKeever,1994; Walker,1983). Such responsibilities include managing illness in a family member, making decisions about, and providing treatment to, family members as well as playing a central role in fostering the healthy development of children and youth and supporting elderly family members. Increasing numbers of women fulfill such

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time it is cited. If there are more than three authors, subsequent citations will include the first author followed by et al.

responsibilities while also participating in the paid work force. Meeting such demands becomes more challenging when women have few material resources, or have limited networks of support, perhaps because of their newness to a community, and are in situations where formal resources are unavailable or inaccessible to them. While numbers of studies have illustrated how capable women are of assuming such roles and fostering health in the family, often with limited support, such research also points out the costs associated with doing so and draws attention to the need to identify women who may face more difficulties because they are in an at risk group.

As well as providing a context for learning about healthy lifestyle patterns, it has been demonstrated that families set a health promotion agenda and actively participate in negotiating ways to achieve health goals (see for example, Valach, Young & Lynam, 1996). As families progress through the lifespan the nature of concerns about health shift according to the needs and developmental stage of different family members. While considerable attention has been paid to family health in the perinatal and early childhood periods less attention has been paid to family health initiatives during adolescence or later years. Most frequently health promotion initiatives have focused on the identification of behaviours that place a person at risk for contracting a particular illness. For this reason a principal focus of nursing actions has been on health education or other forms of behaviour change. However recent work suggests that family health concerns during adolescence are focused on maintaining well being by protecting adolescents from harm and fostering relationships (Lynam & Young, 2002; Young, Lynam, Valach, Novak, Brierton & Christopher, 2001). This work suggests there is a need to consider the perspective of population groups in determining health priorities or considering approaches to care delivery.

Questions have been raised about the adequacy of health education in meeting the broader health promotion agenda. As such, work on health promotion has added the exploration of peoples' capacities to act on health knowledge and the examination of processes of creating healthy communities by promoting change at the systemic level (Wallerstein, 1992) to the health promotion repertoire.

In recent years there have also been calls for programme and practice initiatives that recognize behaviours as mediated by social structures which influence the individual's capacity to act (Anderson, Dyck & Lynam, 1997; Davies & Macdonald, 1998) in an effort to understand why groups do not respond in similar ways when pursuing health or managing illness.

The population of interest in this study is immigrant women. Immigrant women are faced with challenges associated with resettlement in their new countries and, like other

women, are assigned major responsibilities for promoting the health of their families as well as caregiving for family members facing illness. In previous research I examined immigrant women's approaches to establishing networks of support subsequent to migration (Lynam, 1985) and offered understandings of the challenges associated with, and benefits of, entering the lower echelons of the workforce and managing paid and unpaid work roles (Anderson & Lynam, 1987). These studies made visible the importance of the informal sector as a resource for women. Subsequent work explored parents' and teens' goals and actions related to promoting health within the family. In these studies the informal sector was a source of information about health and health resources and, particularly for teens, a site where relationships were established and new ideas about health were explored.

Other studies I have undertaken with colleagues examined immigrants' approaches to illness management. This research, and other studies within the broader programme of research illustrated the ways in which illness management experiences were socially organized and drew attention to the ways decisions made within the formal health care sector (about resources or programmes) influence experiences (see for example, Anderson, 1990, 1996; Anderson, Dyck & Lynam, 1997; Dyck, Lynam & Anderson, 1995; Lynam, Henderson, Browne, Smye, Semeniuk, Blue, Singh & Anderson, 2003).

These studies were undertaken to fill gaps in our understanding about the unique challenges immigrant women face and to provide direction to practitioners seeking to enhance the effectiveness of their approaches to care by working with, creating new, or strengthening existing community based resources. These studies were however, undertaken in a particular social context. That is, they were undertaken in Canada at a time when efforts were being made to ensure barriers to service delivery for new immigrants were identified and dismantled. This was also a time of change in patterns of migration that prompted practitioners to call for new understandings about their changing client population and the ways social changes were influencing the practice context.

The approaches taken in much of the research I have been involved in aligned with the work of scholars seeking to examine women's experiences in their social context. For, as has been increasingly recognized by feminist scholars, there are multiple influences on women's experiences. For example, the case has been made that the challenges many women face are not because of their sex but because of their gender. That is, historically women are more likely to be poor, because of their differential status as wives or because the workforce has historically assigned wages and work roles on gendered lines. Such analyses have been drawn upon in arguing for changes in social and labour policies; creating for example policies of equal pay for work of equal value or eliminating sex as criterion for work roles. Similar

arguments have been made about 'race'. Increasingly therefore, population based studies that document trends are being complemented by studies that consider the ways such trends are produced. One trend of concern is that immigrants are more likely to be living in poverty than their Canadian or British born counterparts and that women, particularly women who are heads of households, are more likely to be poor (BC, 1998, Chen, Ng & Wilkins, 1996; Nazroo & Davey Smith, 2001). Analyses of profiles of health inequalities draw attention to the fact that over the life course these are groups of people more likely to experience inequalities in health.

The programme of research in which I have been engaged highlights the importance of communities as sources of support and resources for women and identifies the challenges that must be faced in attempting to develop networks of support. This work and the work of others (Anderson, 2000; Browne, 2001; Reimer Kirkham, & Anderson, 2002) also illustrates the ways in which individuals' experiences are shaped by broader institutional processes. This study builds from this earlier work and seeks to extend our understanding of immigrant women's experiences and to explore in particular how women of colour navigate their local communities.

Like Canada, researchers and practitioners in Britain have been concerned to ensure that all sectors of their population, which includes a substantial number of people of different ethnocultural backgrounds, receive needed support and resources. Both countries have recognized the informal sector as a resource for health in their health policies and action plans (Britain, DoH, 1999, Cm 4386, DoH, 2003; Canada, 1986). Exploring a similar question in two different social and political contexts, offered the possibility of enriching our understanding of the ways social context can influence experience.

Britain has played a leadership role in producing scholarship related to cultural studies and social theory. As well, scholars in Britain have made noted contributions in the field of culture and health which has been influenced by theorizing about the social position of women of colour and the role of policy. Williams (1989, 1996) for example is noted for her examination of the ways in which women of colour have been constructed in social policy and how this shapes women's experiences within the social welfare system. Her work has illustrated the valuable insights that can be gained by stepping back and examining assumptions that underpin policy.

My research has focussed upon immigrant women, who were also women of colour, because practitioners observed that this segment of the population had needs that were not well understood and were deemed to be at risk because they faced barriers in accessing health care services.

While often referred to as such, it must be noted that not all women of colour are immigrants for, in both Britain and Canada, many people of colour are second or third generation descendents of immigrant families. Nonetheless, it has been argued that people of colour, regardless of their country of birth, tend to be represented as people 'from elsewhere', as newcomers, or as foreigners. While such representations and their implications have received considerable attention (bhabha, 1994; Hall, 1990, 1996a,b; Noel, 1994) it is only in recent years that processes of 'othering', to use Hall's term, are thought to have consequences for health. For example, recent studies suggest racializing practices have a cumulative negative effect on health (Williams & Williams-Morris, 2000). Additionally, racializing practices have been identified as having a negative influence on an individual's sense of self (Dion, Dion & Pak, 1992; Freire, 1993; Jiwani, Janovicek & Camereon, 2002; Khanlou, Beiser, Cole, Freire, Hyman & Kilbride, 2002; Lillie-Blanton & Laveist, 1996; Noh, Beiser, Kasper, Hou & Rummens, 1999; Rogers, Adamson & McCarthy, 1997; Rumbaut, 1994) which is of particular concern when youth are involved.

It is important therefore to seek first generation immigrant women and their daughters' viewpoints on the nature of their relationships with others in their new communities, to explore what resources they draw upon and to consider how organizational practices and institutional policies may influence these experiences. This is the purpose of this present research.

Using the case of first generation immigrant women to Britain and Canada, and their teenaged daughters, this research will explore the nature of their relationships with others in the community, their views of the formal and informal resources available to them and their involvement with such resources. In particular it will explore their appraisal of the informal sector as a resource for them subsequent to migration. It is hoped that such an exploration will provide new insights into the conditions that enhance or diminish the capacity of population groups described as vulnerable or at risk.

A challenge in undertaking such an examination is identifying a theoretical perspective that provides direction for considering individuals' experiences in their broader social context and for considering policy implications. As I approach this work with an overt attention to practice, I am also interested in introducing a different voice, that of women and teens, into the policy discourse.

Tenets of a Critical Theoretical Perspective

A critical perspective was favoured for its potential to prompt reflection upon assumptions inherent in our theorizing while also creating an avenue for introducing

alternative perspectives into the programme and policy development process. The theoretical perspective drawn upon must therefore meet particular criteria.

Guba and Lincoln, (1994) known for their wide ranging contributions to qualitative inquiry, have developed a preliminary characterization of critical theory while comparing it to other perspectives. Their analysis therefore offers a starting point for identifying the criteria such a theoretical perspective must meet. In their view the aims of critical inquiry are "critique and transformation; of the social, political, cultural, economic, ethnic and gender structures that constrain and exploit humankind" (Guba & Lincoln, 1994, p. 113). Further they assert that the researcher is required to recognize the "historical situatedness" of the phenomenon of interest. To accomplish this the researcher must appraise the ways history has shaped the context of interest and use the analysis to initiate or further "dialogue" as a strategy for transforming the ways the phenomenon is viewed. While dialogue may contribute to transformation, the long term goal is organizational change, which usually evolves from policy change.

Harvey (1990) also discussed the purpose of critical social research. His view aligns with that of Guba and Lincoln (1994). He asserts critical social research is intended to cut through surface appearances by examining phenomena in their historical context.

> "Social structures are maintained through the exercise of political and economic power. Such power ...is legitimated through ideology. Critical social research thus addresses and analyses both the ostensive social structure and its ideological manifestations and processes" (Harvey, 1990, p.19).

A critical perspective offers another way of examining a particular problem. Even though theoretical perspectives endure and are drawn upon to frame research in their respective domains any theoretical perspective has limits. That is, there can be other ways of making sense of, explaining or accounting for, a phenomenon. For example, in Hall's (1996a) use of Marxism as a case from which to examine ideology he observes:

> "One-sided explanations are always a distortion. Not in the sense that they are a lie about the system, but in the sense that a 'half-truth' cannot be the whole truth about anything. With those ideas you will thereby produce an explanation which is only *partially* adequate --and in that sense 'false'" (p. 37).

Drawing upon a different theoretical perspective can enable us to take another view, to posit another explanation or to illustrate consequences that may have not been considered.

In undertaking critical inquiry Guba and Lincoln (1994) indicate the researcher must make visible the assumptions being brought to the research. In selecting the theoretical

perspective for this study I sought a lens that would, as a basic premise, accord recognition to the viewpoint of those largely overlooked in the policy process. In this case I build from the position of researchers and theorists who recognize individuals' experiences are socially organized and who have shown that women who face multiple forms of disadvantage such as women of colour, women of limited material means, and women in the lower echelons of the workforce, are largely outside of the policy process. In undertaking this research therefore I seek to make visible women's experiences and drawing upon Dorothy Smith (1987a,b, 1990) and Pierre Bourdieu (1986,1990a,b, 1994, 1997, 1998; Bourdieu & Wacquant,1992, Bourdieu, Accardo, Balazs, Beaud, Bonvin, Bourdieu, Bourgois, Broccolichi, Champagne, Christin, Faguer, Garcia, Lenoir, Euvrard, Pialoux, Pinto, Podalydes, Sayad, Soulié, Wacquant, 1999) reconstruct them, examine them, and discuss them in relation to the prevailing policy discourses of the countries of interest.

Thus far I have introduced the study in relation to my own programme of research. In what follows I locate this programme in the broader social and theoretical context and in so doing begin to illustrate why a critical perspective is appropriate. I also set out to illustrate why the theorists I have chosen to draw upon are well suited to guide this study. As such inquiry must take into account the historical situatedness of the problem. I begin by introducing historical influences on the patterns of migration to Britain and Canada.

Patterns of Migration: Britain and Canada

Both Britain and Canada have substantial immigrant populations and as a consequence have societies that are characterized by diversity. In recent years however, attention has been drawn to the need for each country's systems of health care, social services and education to consider whether existing systems provide services in ways that are culturally relevant.

Britain

The pattern of migration to Britain has been influenced by its colonial history. While many people moved to Britain in recognition of its prominent position in the international community the majority of Brtiain's immigrants have enacted rights to migrate associated with family ties as descendants of persons born in Britain or rights accorded citizens of Commonwealth countries. Immigration to Britain is not new but it has increased since the end of the second world war. Between 1978 and 1998 Britain accepted between approximately 46,000 and 70,000 adults and children, immigrants and asylum seekers for settlement each year. In 2000 alone, 125,100 persons were accepted for settlement. The year

2000 was a peak year, as the government made an effort to clear a backlog of applicants many of whom had been waiting for a decision from one to four years (Britain, Home Office (HO), Jackson & Bennett, 1998, Oct).

While many immigrants speak languages other than English as their first language, the majority of those from Commonwealth countries have had education in English. As in Canada immigrants are dispersed throughout the country however the largest concentrations are found in major cities, particularly those with an industrial base.

The profile of migration to Britain from what is often termed the 'new Commonwealth' means that many newcomers are visibly different from the British born. Although migration to Britain, particularly from the Indian sub-continent and Africa, has continued in recent years Britain has seen a shift in the source countries of persons applying for immigrant status, or asylum. Applications from Eastern European countries, Asia and the Americas have been noted (Britain, HO, Jackson & Bennett, 1998, Oct) therefore attending to language and cultural issues has become increasingly important. It is estimated that 30 - 40 per cent of the population of the city of London report an ethnic background other than British (Alexander, 1999; Hillier, 1997; Silvera & Kapasi, 2000; Key Informant Communication, May 1999; Dec. 2001).

In keeping with the provisions of the 1951 United Nations Convention on the Status of Refugees both Canada and Britain accept applications from individual Asylum Seekers (Britain) or Refugee claimants (Canada). Both countries have also accepted Convention Refugees.

Considerable attention has been paid in scholarship in Britain to the treatment of Blacks in British society. The issue of visibility, the meaning of culture, and the racialization of groups have received considerable attention and debate (Ahmad, 1993a,b, 1996; Bradby, 1995; Hall, 1996b; Hillier & Kelleher, 1996; Kelleher, 1996; Nazroo, 1999; Nazroo & Davey Smith, 2001; Williams, 1996). This overview recognizes that there is interest in Britain in understanding issues faced by different sectors of the population and an interest in exploring their potential influence on health. Key works in literature addressing issues of diversity and health will be examined in greater detail in Chapter 2.

Canada

Canada also has a substantial population of immigrants or descendents of immigrants. Unlike Britain, Canada also has an indigenous (First Nation, FN) population. Early immigrants came as settlers to British and French colonies established in Canada. The influence of these two founding nations are in evidence today in Canada's formal structures,

such as its two official languages and systems of government, and in informal structures as reflected in social and cultural events. So too the largely negative impact of colonization on FN peoples is in evidence. It must be noted that FNs are recognized as the most vulnerable sector of the Canadian population. While some conditions (such as poverty or racializing practices) that contribute to this profile are likely similar to those experienced by immigrants, FN peoples, and the health care services for them, have a distinctly different structure, criteria for eligibility, social and political history. For these reasons, and because they have no counterpart in Britain, this study has not included this population and the considerable literature related to it.

In the 1996 census five per cent of the Canadian population was categorized as immigrant. When examining the profile of settlement however, as in Britain, the majority of immigrants have settled in major urban centres. In BC for example the majority of new immigrants live in the area surrounding Vancouver, the province's largest city. In 1996, about one in four persons in living in Vancouver was an immigrant or refugee (Canada, Statistics, 2001).

Until two decades ago the majority of immigrants to Canada were from European countries. In the past two decades there has been a shift in source countries. Before 1961 more than half of Canada's immigrants came from three source countries: the UK (33.9 per cent), Germany (12.4 per cent) and the Netherlands with (9.2 per cent). For those immigrants arriving between 1991 and 1996 the top four source countries were Hong Kong (21 per cent), China (13.1 per cent), Taiwan (10.5 per cent) and India (10 per cent), comprising approximately 55 per cent of all immigrants in the time period (Canada, Statistics, 2001).

While many immigrants have English language skills the majority speak languages other than English as their first language. The majority of new immigrants are accepted on the basis of a system that accords points for English or French language fluency, educational level and job skills. Persons accepted for immigration under this system therefore are deemed to have the skills needed to participate in the labour force and are considered economic immigrants. Family class immigrants, usually those immigrating to join a family member, constitute 27.7 per cent of immigrants while refugees and others comprise another 8 per cent (Canada, 1998a,b). Immigrant men and women participate in the labour force in full time all year jobs at rates higher than their Canadian born counterparts (BC, 1998, p. 26). Nonetheless, immigrants arriving to Canada have incomes considerably lower than their Canadian born counterparts. This discrepancy was documented at $5,000 for those arriving between 1986 and 1990 and increased to $10,000 for those arriving between 1991 and 1996 (BC, 1998).

Despite being societies characterized by diversity there is evidence that some sectors of the populations of both countries do not sustain their health status, or achieve similar socio-economic status (SES) as others. In what follows I examine literature that draws attention to links between migration and health. This literature and literature to be reviewed in greater depth in the next chapter suggests that health of immigrants is influenced by material resources, gender, employment opportunities and racializing practices of the broader community.

Migration and Health in Britain and Canada

Immigrants to Canada generally have higher rates of wellness than their counterparts in their countries of origin and rates of wellness comparable to, or higher than, the broader population at the time of migration. Such profiles of wellness however deteriorate over time, as rates of disease among immigrant groups begin to approach that of the general population after living in Canada (Chen, Ng & Wilkins, 1996).

Abel-Smith (1994) reports that in the UK "all immigrant groups have higher mortality than the average for England and Wales for tuberculosis and accidents but lower in the case of bronchitis" (p. 29). Of these figures and an observed variability on a number of indicators for different ethnic groups he asks: "Are the high rates due to poverty, the stress of immigration or discrimination? The question is still unanswered" (p. 29).

Nazroo and Davey Smith (2001) are among a number of scholars in Britain arguing that social class alone does not provide a sufficient explanation for documented inequalities in health. They observe that in Britain "within each class group ethnic minorities had a smaller income than white people" (p. 47). This observation raises the possibility that income is an indicator of another phenomenon.

A study examining poverty among immigrants in BC, noted that in 1996 among the general population, children living in one parent families have the highest rate of poverty of all family types. However, it was also noted that working status did not protect families from poverty. For, 23 per cent of the immigrant families living in poverty had all adult family members working full time while in another 35 per cent of these poor families adult family members were working part time (BC, 1998).

The research on health inequalities undertaken in the UK suggests that immigrants and citizens whose families have been living in the UK for two and three generations are over represented in the lower echelons of the labour force, more likely to be living in poverty and among those experiencing higher rates of illness. The research cited here suggests therefore that inequalities in health are not solely the result of class and 'race' but rather there may be

other processes operating that contribute to class position and poorer health over the life course. While research on health inequalities will be examined more fully in subsequent chapters, this work and research that has demonstrated links between health and peoples' connection with their communities suggest that the individual-community interface merits further exploration.

The evidence suggests that the majority of immigrants arrive healthy and with skills to participate in the workforce. However, health status declines over time. As both countries have considerable populations of immigrants it is reasonable to assume that preserving their health would be of interest.

Mobilizing Resources of Informal Systems: Promising Health Interventions

My programme of study underscores the integral role informal support networks play in illness management and health promotion and draws attention to the differential capacity of different groups to mobilize supports or resources. Increasingly professionals are called upon to demonstrate they have considered the needs of groups within the community in developing resources or implementing programmes. It is becoming evident that unless we examine assumptions underlying the premises of practice we may not be aware of who may have been overlooked in such programme or resource development decisions. Frequently for example, programmes and resources, and our means of assessing our clients, are informed by viewpoints that have been developed from, or for, the 'average' member of the population.

In his exploration of the issues surrounding migration bhabha (1994) writes about the consequences of living in a society that is organized to respond to the 'average' individual when one is not 'average'. In such contexts he observes "subjects are disproportionately placed in opposition or domination through the symbolic decentring of multiple power relations" (bhabha, 1994, p. 72). While bhabha's work focuses on experience and does not make links to health, his writing does prompt us to consider that immigrants' views may differ from those of the broader society. He also suggests that structures, processes, language and associated actions of persons within society play part in shaping immigrants' experiences.

bhabha's perspective aligns with the work of theorists who conceptualize health care systems as cultural systems and illustrates the potential consequences that can accrue if such systems to not adequately take into account the experience of newcomers, persons with different life experiences, and persons who may approach the system with a different set of assumptions, and resources.

Domains of Influence on Health: Perspectives on Health Inequalities

Considerable theoretical and empirical work has been undertaken to explore the ways in which health is defined and to understand how social determinants of health exert their effect. There is a dialectic relationship between how health and health services are conceptualized in theory and how such conceptualizations are taken up in policy. As knowledge in one area develops, conceptions in the other are revisited and in some instances revised. The link between poverty and health has received considerable attention in recent years. While research on health inequalities will be examined in greater depth in Chapter 2, I briefly raise here a number of observations from health inequalities research that are pertinent to how this study has been conceptualized. Increasingly health research has acknowledged that social conditions have an impact upon health. While the mechanisms of influence are still being explored, work in this area is broadly referred to using a number of umbrella terms. For example in Britain health inequalities research refers to population studies that have documented that inequalities in health status are associated with such variables as income, social standing and gender. In Canada the umbrella term used is social determinants of health even though research in this area, like in that undertaken in the UK, generally refers to population studies documenting associations (rather than causal relationships) between social conditions and health status. Social determinants of health, or health inequalities, are descriptors being used to accord recognition to research that has established links between social phenomena and health status in the short term or over the life course.

The first and most frequently cited example of research into inequalities in health is commonly referred to as the Black Report (Townsend & Davidson, 1992). This study demonstrated links between a number of social conditions and health and showed that those living in poverty in Britain were more likely to die at an earlier age than those with better living conditions. The researchers posited a number of explanations for these findings, which will be explored more fully in the chapter to follow. The findings of this study were deemed so important it is credited with launching a host of studies into health inequalities throughout the world. Britain has since commissioned several follow-up studies.

Whitehead (1992) undertook the first comprehensive follow up to the Black Report. Although she modified some measures her research corroborated and extended the conclusions of the Black Report, noting persistent links between poverty, ethnicity, gender and poor health.

The Acheson Inquiry (Britain, DoH, 1998a,b) further explored these links and established that health inequalities are not solely the consequences of poverty but rather the

ways poverty contributes to the creation of the social condition of deprivation. This inquiry examined more closely who was living in poverty and the profiles of those at risk and noted that groups at risk for health inequalities include youth living in poverty, women and ethnic minorities. These researchers also showed that disadvantage is cumulative over the life course. The mechanisms of effect are still being explored but this report suggested that the social organization of the community, and the accessibility of social and health resources, have an influence on inequalities in health (Gordon et al, 1999).

Health inequalities research is important for a number of reasons. One is that it has shown that the biomedical model and research based on it, has not fully accounted for population health profiles and does not provide direction for all modes of intervention that may improve the health of populations. However, while research on inequalities in health has made considerable advances, the mechanisms whereby these conditions exert their effect are still being explored. The theoretical perspectives informing such work are important, because they potentially offer direction for policy or practice. As with other research however, evidentiary links between phenomena may be established but policy directions are not always clear.

While the Black report and subsequent research have been particularly influential in focussing attention on links between social conditions and health other research has also introduced promising perspectives. For example, in addition to corroborating findings of research in the UK related to poverty and health, the Alameda County study was one of the first studies to draw attention to the links between social environment, particularly social networks, and health status thereby introducing new evidence related to the ways social conditions can exert their effect on health. Haan and colleagues (1987) undertook a 10 year follow up of original study participants and concluded:

> "Overall, these research results, supported by similar findings elsewhere...suggest that ... the persistent and pervasive link between socioeconomic position and disease should include assessment of the social and physical environmental demands to which persons of lower socioeconomic position are exposed" (Haan, Kaplan & Camacho, 1987, p.995).

This brief overview draws attention to the importance of understanding ways the social environment exerts its impact upon health and introduces ways these effects have been conceptualized. These themes continue to inform research on health inequalities and to guide policy initiatives (Britain, DoH, 2003; Canada, 1986).

The study that is the focus of this thesis aims to make a contribution to our understanding of the ways in which social influences exert their effect on health and to generate insights into informal resources for health by examining the nature of relationships women establish and draw upon within their communities.

Conceptions of Culture and Health

As has been suggested above 'ethnic minorities' and women of limited means are groups at risk for health inequalities. As such, one approach has been to explore links between culture and health in an effort to account for patterns of health inequalities. The concept of culture as a discrete explanatory variable however has been questioned and debated. A central issue is how culture is conceptualized for, in many views culture is presumed to embody a static set of behaviours, beliefs and practices and is frequently conflated with ethnicity. One line of argument is that to make such assumptions is to deny the existence of diversity (of education, of beliefs, of material circumstances, of health practices and of placement and roles in society and the broader community) within ethnocultural groups. Literature related to this will be examined more fully in the chapter to follow however, here I introduce ways in which the concept of culture has been drawn upon to reconceptualize our view of health care systems and work that directs us to reconsider the ways in which health and the health care system have been conceptualized.

Links may be made between our view of formal and informal systems and the work of theorists who have conceptualized domains of health knowledge as cultural systems. Here I refer to the work of Kleinman, (1978) who is one of several theorists (Chrisman, 1977; Chrisman & Kleinman, 1983; Eisenberg & Kleinman, 1980; Good & Good, 1980; Helman, 2000; Kirmayer, 1988; Lock & Gordon, 1988) whose work has been instrumental in providing direction for examining health systems as cultural systems. As such this work has illustrated that within each system health may hold different meanings.

A series of studies undertaken by the author and colleagues (see for example, Lynam & Young, 2000; Valach, Young & Lynam, 1996; Young, et al, 2001) focused on the ways in which health was jointly constructed in conversations between parents and adolescents. In many situations the adolescents contested family traditions or approaches to maintaining health. The adolescents' definitions of health incorporated physical well being but emphasized relationships and noted in particular the importance of being respected, valued and heard by parents but also by others. In addition, this research showed that parents' concerns about health were frequently overshadowed by concerns about safety and a concern

to ensure the adolescent's social well being. This work suggests that family perspectives on health and illness are not necessarily consonant with professional viewpoints.

This research suggests that each cultural system (i.e. family, community and/or health care) is organized around different premises and, as such, draws upon different resources, knowledge sets and types of expertise. As well, people operating within these systems set, or reconcile, priorities according to competing demands. For transactions across and between sectors to be effective therefore there must be an awareness of, and a capacity to attend to, the conditions that shape the capacity to act and structure responses at the level of the system.

As the informal sector has an identified role to play as a resource the research interest here is in understanding the nature of first generation immigrant women's relationships within the community and exploring with these women how their relationships or connections are drawn upon as resources for health.

Reconceptualizing Health Interventions

Recognition of the influence of social conditions on illness profiles has meant that in recent years views of health have shifted to include influences outside biomedicine. Similarly, the health promotion agenda has been broadened to recognize the dual influences of individuals' behaviours and social structures on health. With respect to these, strategies for promoting health have incorporated initiatives at the social-organizational level and include creating supportive environments, fostering community action while also focusing attention on the development of personal skills.

While traditional public health initiatives to minimize the spread of disease are still important components of health promotion or disease prevention, strategies for undertaking these have incorporated an additional goal of 'enabling people'. As such, the concepts of partnership and empowerment, or capacity building, are frequently viewed as central to initiatives in each domain of intervention.

In a recent forum focusing on health promotion, (World Health Organization (WHO), 1997b) fostering empowerment and working in partnership were advanced as strategies for fostering health of individuals and societies. The WHO conceptualization underscores the importance of focusing attention on creating healthy social environments. This is in keeping with recognition of the importance of initiatives at the macro level, such as the creation of healthy environments through public policy and by creating structures to foster health through community development (Chalmers & Kristajanson, 1989; Hamilton & Bhatti, 1996; Lomas & Contandrioupoulos, 1994).

In reconceptualizing professional roles in health, Butterfield (1991) observes that models of disease prevention have not historically recognized that for some, healthy choices are constrained by a number of social conditions or factors, largely outside their control. She draws upon the work of other theorists to support her assertion that social change can result when larger dimensions (such as social or structural conditions) influencing health are made visible. Butterfield (1991) notes that a focus of health care intervention should include the creation of social conditions that can create a context that can "expose power imbalances that prohibit people from achieving their full potential" (p. 70). As such, Butterfield's recommendations are consistent with those theorists who recognize ways structures can constrain (or facilitate) individuals' action.

Wallerstein (1992) extends this view and examines different perspectives on empowerment as a strategy for fostering health. She observes that some restrict their definition to a change in individual behavior or perspective, while others focus more on the role of community and community structures and processes in creating opportunities for participation as a means for effecting change and enabling a person to acquire a sense of 'competence'. Wallerstein's perspective on empowerment which draws upon Freire's (1970, 1998) work is important for it introduces the dual roles of *structural constraints and the individual's capacity to respond* as concurrent considerations.

It is clear that families and community networks are seen to hold central roles in creating and sustaining health (Canada, 1986, 1987; Jowell, 1997; Spurgeon, 1998). Being part of a supportive social network has been shown to reduce risks of ill health. One health promotion strategy is to foster participation as a means for developing resources or programmes while also accruing the positive effect of being engaged in creating solutions. My research has involved people who, for a number of reasons, are either in the process of developing new networks of support or seeking specific types of support to manage an illness or developmental stage of a young family member (Anderson, Dyck & Lynam, 1997; Lynam, 1985, 1990, 1992, 1995; Lynam & Tenn, 1986, 1989). In each study one feature of the difficulties the participants faced was in negotiating the type of support they needed. Often this process involved getting to know new resources or meeting people in other sectors of the community. One group who faced particular difficulties was first generation immigrant parents of adolescents. Research undertaken by the author and colleagues identified that one source of concern emerges from the parents' lack of familiarity with the new community and their uncertainties about how to guide and protect their adolescents as they set health goals and foster development (Young & Lynam, 1995).

Youth whose families have immigrated to a new country often find themselves at the interface of two cultures and two communities (Frière, 1993). The processes of reconciling parental and youths' viewpoints on their historical culture within the context of their new communities represents a challenge and, for some, prompts a crisis.

There is some work that has sought to understand conditions that contribute to the creation of health risk for vulnerable populations and to identify conditions that can mitigate risk (Werner, 1989). Werner's research is unique in that he followed a sample of infants deemed 'at risk' from infancy through to adulthood. His longitudinal study undertaken in the US identified three types of protective factors all located in the informal sector. These include capacity of the child to develop relationships with others, affectional ties within the family to provide support during times of stress and the presence of an external support system. Werner's research raises questions about the capacity of families undergoing change subsequent to migration to offer the types of support needed to mitigate risk. Much research characterises resilience as an inherent trait or characteristic of individuals. Werner's research however, also recognizes that many of the resources for resilience accrue from relationships and are located within the informal domain. As such, if health care professionals are to become engaged in fostering resilience they would have to work through the community to ensure there were mechanisms in the system that could foster the types of relationships shown to make a difference.

Nurses, and other health professionals, enact a variety of roles in working with families in the community context. Frequently this work is one to one; seeking to mobilize family resources, teaching, or providing direct care. Increasingly however, professionals are thwarted in their efforts to work with families because of a lack of resources or a lack of recognition at a system level of the circumstances that mediate families' capacities to act to meet their health care needs. Such observations provide one of several reasons advocacy and community development have become aspects of their practice. Increasingly it is being shown that to be effective individual focused interventions must be coupled with initiatives that work to address structural barriers to care delivery. Cowley and Billings' (1999a,b) work exploring clients' views of health for example, directs health visitors to focus on enabling clients to manage presenting problems while also exploring means of addressing the wider situation.

While there is considerable evidence that health is influenced by processes not accounted for within biomedicine there is still much to be learned. A substantial body of research has sought to explore the complex relationships between social and material well being and health. As noted by MacIntyre (1997) despite considerable efforts at teasing out

variables and clarifying methods of measurement in order to explore the ways in which different conditions, including gender, race and class exert an effect on health, there are still a number of important questions requiring answers. She asks "what are the precise mechanisms or pathways by which social inequalities in health are generated and maintained in particular contexts and what effective actions, if any, can be taken to reduce, or ameliorate the effects of social inequalities in health?" (p. 740).

If we are to work effectively with the processes influencing health we need to have a greater understanding of the ways in which social conditions exert their effect. Asking people who are in populations seen as vulnerable is one way of exploring such questions.

Is the Informal Sector Explicated in Policy as a Resource for Health?

The literature reviewed above has drawn attention to the importance of the informal sector as a resource for health. In what follows I provide a brief overview of the ways in which Britain and Canada's health policies view the role of the informal sector and in doing so begin to draw attention to assumptions inherent in particular policy perspectives.

Both Canada and Britain have universal systems and are therefore committed to providing comprehensive care without a fee. The British NHS began as a system to provide hospital based care and has since developed to include community services (Rivett, 1997).

The Canada Health Act articulates the principles guiding the development and delivery of health services, in both hospital and community, for illness and health promotion, throughout Canada. Responsibility for delivering service is however, accorded to the provincial governments. The funding and delivery of health care services is therefore dependent upon a co-operative arrangement between federal and provincial jurisdictions which leaves considerable room for negotiation and interpretation at provincial and regional levels (Gray, 1991; Meilicke & Storch, 1980). Ensuring equitable access to care throughout the country is one of five principles underlying Canada's national health system.

Health policy in Britain has, in the past two decades, affirmed the commitment to universal care but has explored ways of doing so while containing costs. A series of initiatives outlined in the 1989 White[2] paper "Working for Patients" (Britain, DoH, 1989) sought to enhance the productivity of the NHS. This policy, implemented in 1991, espoused values of self reliance, and self sufficiency over dependency on the state (Klein, 1995). Hence in this era, biomedically driven priorities were replaced in part by efficiency driven priorities

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[2] "The terms "White" and "Green" Paper are not precisely defined, though in broad terms White Papers contain statements of Government policy while Green Papers (often termed 'consultative' documents) put forward proposals for consideration and public discussion" (Britain, Official Documents, The Stationery Office Ltd, 1997, Aug.20).

where efficiency was measured in terms of such performance indicators as numbers of surgical procedures, waiting lists and length of hospital stay. The National Health Strategy for England, published in 1992, recognized the need for illness care but also acknowledged the need for more input on the nature of services at the community level. This policy era also accorded greater responsibility to local health authorities who were then "responsible for translating national objectives into local policies and for working with other agencies to address the conditions which give rise to ill health" (Spurgeon, 1998, p.6).

The social determinants of health received renewed attention in policy in 1997. The 'Our Healthier Nation' Green paper launched at that time by the British Minister of Public Health promised to tackle the root causes of ill health through policy and programme initiatives. The Green paper recognized that ensuring the health of the public requires action across a range of social structures. In particular, he made a commitment to:

> "respond to the health gap within and between societies; and to tackle the inequities in health produced by the rules and practices of these societies. ...(A)nd....to acknowledge people as the main health resource; to support and enable them to keep themselves, their families and friends healthy through financial and other means, and to accept the community as the essential voice in matters of its health, living conditions and wellbeing" (Spurgeon, 1998, p.27).

These policy commitments recognize social influences on health and that resources of the informal sector, particularly relationships, as resources for health. These were followed by the consultation document "Our Healthier Nation" (Britain, DoH,1999a) and its White Paper sequelae "Saving Lives: Our Healthier Nation" (Britain,DoH, 1999b, Cm 4386). These policies extend the concerns identified by the Minister in 1997 and promise to address health inequalities.

> "Health inequalities are widening. The poorest in our society are hit harder than the well off by most of the major causes of death. In improving the health of the whole nation, a key priority will be better health for those who are worst off" (Britain, DoH, 1998d, Cm 3852, p. 4).

In this document responsibility for ill health is shared by the community. Working in partnership is espoused as a key strategy for achieving the aims expressed above.

This has been a very active era of policy development in Britain. Since these study data were gathered new policies have been published (Britain, DoH, 2000a,b,) consultations have been undertaken and an implementation plan has been developed (Britain, DoH, 2002, 2003, July) all with a view to redressing inequalities in health.

Canada's health policy is meant to provide direction to ways in which the principles of universality, equity, portability and accessibility can best be operationalized. The importance of the informal sector to health care is also recognized. One premise of Canada's policy is that achieving health and fostering effective illness management is contingent upon people being a part of a healthy network of support and having the capacity to offer support to, and derive needed support from, others (Canada, 1986). Strategies for implementing this policy emphasize participation, partnership, empowerment and community building (Canada, 1986).

Provinces are mandated with the delivery of health services but must do so within the framework of national legislation and policy. The health policy in place at the time this study was undertaken in BC for example, proposed a number of strategies to support the goal of providing care 'Closer to Home' (BC, 1992). This policy recognizes the pivotal role of the informal sector in supplementing health services and proposes strategies to mobilize community support. The strategies incorporate many of the principles of partnership and participation inherent in the national policy, related to health promotion and illness management and are directed at governance and service delivery. The governance strategies include: fostering community input through the creation of community based health boards and creating specific population health advisory groups.

One outcome of BC's review of health care programmes, undertaken prior to setting the agenda for reform, was the recognition that a number of population groups are at risk for poorer health than the broader population. While a number of reasons have been put forward for this discrepancy those that appear to have the most salience relate to the role played by 'determinants of health' in creating risk. In this same review it was also noted that the population groups identified as at risk have not had their views reflected in research, health care planning or service delivery. Groups deemed to be at risk include women, cultural communities and youth (BC, 1992). This brief overview has broadly framed the problem of interest in this research, which is summarized in what follows.

Statement of the Problem of Interest

There is a need for a critical examination of the mechanisms whereby social conditions influence health. While a range of theoretical perspectives have been drawn upon to examine, through research, and respond, through policy and programme initiatives, population health needs there is evidence that these do not necessarily account for experiences of first generation immigrant women. Further, despite recognition within health policy that informal systems are resources for health there is evidence that some sectors of the

population have fewer of these resources to draw upon and it has been shown that some population groups are, as a consequence, more vulnerable to poorer health over the life course. Understanding the ways in which the interface between the formal and informal sectors is understood and negotiated may provide insight into ways resources of the informal sector may be fostered and drawn upon. Such insights may in turn enable us to examine how adequately policy considers such experiences.

Research Aims

Using the case of first generation immigrant women to Britain and Canada, and their teenaged daughters, this research aims to explore the nature of their relationships with others in the community, their views of the formal and informal resources available to them and their involvement with such resources. In particular it will explore the nature of informal resources available to, and drawn upon by, them to manage issues associated with settlement and to manage developmental and/or health issues that have arisen for them subsequent to migration. It is hoped that such an exploration will provide new insights into the processes that enhance or diminish the capacity of population groups described as at risk and provide insights to inform a discussion of discourses on culture and health and health inequalities.

Theoretical Perspective

To undertake an inquiry of this nature requires a theoretical perspective that is compatible with the premises of critical inquiry, that accords attention to policy, social processes and intergroup relations and that provides a mechanism for inserting individuals' voices into policy discourse. In conceptualising this study I have drawn upon two theorists whose perspectives are compatible with critical inquiry and the goals of this study and who have articulated specific methods for undertaking research. They are Pierre Bourdieu and Dorothy E. Smith. As these theorists' work has shaped the ways the study was conceptualized and the nature of the research questions asked I briefly introduce them here. The theoretical premises of their work and how it informed the analysis will be examined more fully later in the thesis.

Bourdieu (1990a) affirms the importance of knowledge as a resource and introduces the concepts of *habitus* and cultural capital to recognize the range of cultural knowledge, information and skill drawn upon in enacting day to day life. Such cultural knowledge and cultural capital is created through social exchanges and as 'day to day' work is undertaken. His perspective provides a lens for understanding an individual's 'logic of practice' (1990a). That is, Bourdieu's early work recognized that different societies and the cultural groups

living within them drew upon tacit assumptions about the nature of society to participate in their day to day world. Such assumptions Bourdieu conceptualises as *'habitus'*. Similarly, Bourdieu's work recognizes that different sets of social 'rules' apply in different contexts or what he refers to as 'fields'. To gain entry to a field or to participate in activities within a field different forms of resources are drawn upon, or contributed. Such resources are characterized as 'capital'. Capital can take many forms and can include social, cultural or material resources.

Bourdieu offers an analytic perspective for gaining insight into the logic of practice, for understanding how fields are conceptualised and accessed, and for understanding the processes involved in assigning value to different forms of capital. As such, drawing upon his perspective may enable an analysis that can refine and extend our understandings of links between deprivation or material resources and health to considering the ways in which broader range of capital when available, or recognized, can be drawn upon as resources for health.

Bourdieu conceptualizes the family as a site of both the creation of *habitus* and a forum for accumulating and exchanging capital. Reay (1998a,b) drew upon Bourdieu's concepts in her examination of the ways women participated in their children's education. She describes his conceptualization as useful because he "recognizes the pivotal role mothers play in the generation of cultural capital. It is mothers' time that accrues profits" (1998b, p. 57). Such 'profits' Reay demonstrated are then used to supplement the educational resources of the formal system. Reay also observes, "the family for Bourdieu is both a habitus generating institution and a key site for the accumulation of cultural capital" (Reay, 1998b, p.56). Difficulties can arise however when the mother's *habitus* has been developed in a different cultural context and as a consequence does not provide her with the means for understanding the assumptions of, and a means for engaging with, the formal educational system. As Reay (l998b) writes, "his concept of habitus permits an analysis of social inequality which is not simply dependent upon fixed notions of economic and social location. At the centre of this concept are the social practices which are the outcomes of an interaction between habitus and field. The focus is as much on a process as a position. In terms of my own research project, this focus on process allows me to conceptualize mothers' practices in support of their children's education as part of the generation of social class differences" (Reay, 1998b, p.59).

Bourdieu's conceptualization of *habitus* as a resource drawn upon to guide day to day actions represents *habitus* as dynamic, or capable of change and transformation. As such, it

offers a means for examining taken for granted day to day interactions. *Habitus* lies in one's background, or is taken for granted when life is in harmony.

Bourdieu's (1990a) writing characterizes *habitus* as having a link with the past and towards the future, and while offering the appearance of continuity and regularity, it creates the capacity for the free production of thoughts, perceptions and actions. It performs at the interrelationship of the two states of the social world, the past and the context in which it is drawn upon. It is therefore at the intersection of two social domains, particularly ones that are premised upon different social 'histories' that *habitus* becomes manifest.

Bourdieu conceptualizes *habitus* as a personal resource drawn upon to guide one's day to day life and 'transformation' of *habitus* as the process one undertakes to modify *habitus* to make it work in new social contexts. As is evident from the comments above, Bourdieu's *habitus* is unique. The emphasis on processes versus content makes it amenable to negotiating new understandings, new relationships or new strategies for accomplishing one's work. Additionally, Bourdieu's conceptualization has methodological implications as the disjuncture of one's *habitus* becomes evident at the interface of differing social contexts. It provides us with a point of entry into the examination of such disjunctures.

A central problem for Smith (1987a,b, 1990) is that the 'standard' technique of scientists is to organize, analyse and explain 'subjects' experiences while drawing upon conceptual or analytic tools that bear no relation to many, particularly women's, experiences. One way of resolving this is, in Smith's view, to disrupt the status quo by letting experience speak, thereby making central concepts and issues of concern visible. She admits this goal is, at times, difficult to achieve in part because:

> "the experiences, concerns, needs, aims, interests, arising among people in the everyday and working contexts of their living are given expression in forms that articulate them to the existing practices or social relations constituting its rule" (Smith, 1987b, p. 56).

As such, people may reject their own experiences and take on others' explanations of their situations.

Smith's methodology requires the researcher to begin with the experiences of the populations of interest. While beginning with experience is not unique to Smith's work and has, she acknowledges, been a central strategy employed by feminist writers to make women's voices and stories visible, Smith's method takes this process forward. While Smith's analysis begins by eliciting women's experiences, like Bourdieu, she recognizes experiences as socially organized. Her analytic perspective therefore moves towards an examination of the ways in which experience and broader social structures are linked. As social structures

are created in part as a result of policy and related programme decisions. Smith's perspective offers direction for considering the ways policy can shape or influence experience. In addition to drawing upon women's experiences, her perspective also draws upon texts, as data, to illustrate the ways ideologies are represented.

Both Smith and Bourdieu's work build from the tradition in social science that views knowledge and associated 'realities' as socially constructed. Inquiry drawing upon their perspectives therefore is meant to offer alternative views, draw attention to disjunctures between prevailing views and, in this case, women's experiences. By drawing upon these theorists' perspectives to interpret immigrant women's experiences it is hoped I will provide an analysis that will prompt reflection, consider alternatives and introduce new viewpoints for consideration in policy development, programme development, or service delivery. In effect, I seek to produce an account that can be drawn upon by those concerned to write such women's voices into policy.

Research Questions

Specific questions this study will address are:

- How do first generation immigrant women and daughters view their social location and characterize their relationships with others?

- What resources (forms of capital) do first generation immigrant women and daughters draw upon, and contribute to different fields of encounter?

- What is the nature of first generation immigrant women and daughters' relationships with informal and formal health care systems?

Perspective on Terminology

As the perspective taken in this study draws upon formal documents and theoretical work to provide evidence of particular viewpoints it is necessary to point out what is meant when key terms are being used. Following upon Bourdieu's concept of field, the family is viewed as a central field for teens and mothers and a common point of interface with broader society. However, any insights on family are from the viewpoint of mothers and their teenaged daughters. These mothers and daughters are all first generation immigrants to Britain or Canada and are part of a larger family unit. As such, when speaking of the participants' families I am referring to comments that describe general relationships with others in the family or reflect comments made by a number of mothers and daughters about

their families. When data are being presented the data sources are referred to as mother or teen so the reader is able to determine who is speaking. The country in which the speaker is living is also identified.

Similarly, the study aims to write immigrant women's voices into the policy discourse. Taking direction from Bourdieu and Smith this undertaking begins by interviewing immigrant women and their teenaged daughters. As will be explained more fully as the methodological perspective is discussed in Chapter 3, these women's insights become a starting point for examining national policies of Britain and Canada. However, as the women in Britain all lived in areas of London and the women in Canada lived within the greater Vancouver area their views should not be seen to represent views of all immigrant women to these countries. It is hoped however that their accounts will resonate with other women's experiences and provide insights to prompt reflection.

There are a number of other terms that require clarification. In this study I have taken a feminist viewpoint, that I believe is compatible with Bourdieu's work. Both Bourdieu and Smith's perspectives provide a means for drawing attention to the important role power plays in relationships between women and other persons and social organizations in society. I have therefore drawn upon authors whose work is expressly feminist as well as authors who present themselves as Black Feminists. The work of these latter theorists has emerged because 'mainstream' feminist writings have been critiqued for eclipsing the coinciding influence of 'race' upon the experiences of women of colour. The work of 'mainstream' feminists has been criticised for being more relevant to the experiences of primarily white women living in western industrialized nations and therefore not as useful in explaining how historically constituted colonial relations continue to shape intergroup relations (Bannerji, 1991; bhabha, 1994; Donovan, 1986; Hall, 1996a, 1996b, Maslin-Prothero, 1994).

In my own writing when examining intergroup relations or exploring different theoretical perspectives I have sought to attend to the implied hierarchies inherent in language such as majority, minority; mainstream, alternative. However, the use of such terms in different forms of literature, particularly policy documents, becomes a focus of analysis because it is these discourses that offer insights into what are often taken for granted assumptions.

In this thesis I have aligned the experiences of the women who participated in the research with the experiences of women who have been referred to in a number of different ways in the literature as: women of colour, ethnic minority women, Black (black) women or, referring to their social location, immigrant women. Although the women who participated in the study are not black in that their heritage is not of African descent this literature speaks

to the experiences of persons who are viewed as visibly different from the largely white northern European majority population. These women are visible in that they have different physical features and speak English with a 'foreign' - different - accent. It is this phenomenon of difference that the literature points to as a central feature of their experience (Ahmad, 1992, 1993a, bhabha, 1994; Bourdieu et al, 1999; Hall, 1990, 1996a, 1996b). In citing literature I have kept the authors' format of using lower or upper case or italics in presenting terms.

In addition, I have taken direction from Williams' (1989) work and draw upon her use of terms recognizing as she does the limitations of doing so.

> "I have followed the recent convention of putting 'race' in quotation marks to distinguish it from any biological connotation the word otherwise has... I have used the capital B for Black similarly to distinguish it from mere description. However, usage of the word 'Black' in the following text carries two difficulties. The first is the danger of homogenizing and minimizing the important diversity of histories, cultures and experiences of Black people of different ethnic and geographic origins -- Asian, African, Central American, Latin American...The second is to ignore the widespread racism directed at those other than Black people - in particular in Britain, Jewish, Irish, Chinese" (Williams, 1989, p.ix).

Summary

In presenting the background to the study and conceptualization of the problem of interest in this research I refer to first generation immigrant mothers and daughters as women who are likely to face material hardship and, over the life course, inequalities in health. While the ways in which this effect is exerted are contested there is agreement that groups facing particular risk include those in the lower echelons of the labour force, women, and ethnic minorities.

In delineating the area of interest in this study I have drawn upon literature that supports the view that the informal sector is an important resource for the formal health care system and that relationships between individuals within a sector or between sectors have important implications for health. An overview of the health policies of Britain and Canada and literature on health promotion suggests that resources of the informal sector are resources for health. This is therefore where I propose to begin my inquiry with an overriding goal of writing women's voices into health and policy discourses.

This thesis has eight chapters. In the next chapter I undertake a review of literature to examine more fully the social context immigrants encounter in Britain and Canada and to

examine literature related to health inequalities and literature that locates the chosen theoretical perspective and methods within the body of such work. In the third chapter I provide details of the methodological perspective and describe how the study was undertaken. These are followed by three analysis chapters each focusing on different concepts and processes identified in the data. The subsequent chapter discusses the participants' experiences in relation to the discourses of culture and health and health inequalities. The final chapter summarizes the conclusions and implications of the research.

Chapter 2

Review of the Literature

In order to locate this study in context a number of areas of literature need further examination. I begin by outlining the processes undertaken to identify works drawn upon and proceed to review literature that locates this study in the social and health policy context of the two countries in which it was undertaken. As I am focusing on women new to the countries in which they are currently living I undertake a critical review of literature related to theoretical and substantive issues inherent in conceptualizing culture and undertaking a cultural analysis. The review examines concepts and processes of central importance to the study and identifies criteria drawn upon in selecting the perspective that informed the study design. Literature on health inequalities was introduced in Chapter One because it identifies groups at risk for poorer health over the life course. In this chapter explanations for inequalities in health are examined.

Processes of Review

While considerable literature from a wide range of sources were reviewed for, and incorporated into, this study the process of review outlined here varies from what has recently been referred to as a systematic review. The literature was identified by undertaking searches of a series of databases at several points in the study. That is, searches were undertaken at the outset of the study, prior to gathering interview data and during the analysis subsequent to gathering interview data. The searches generally included literature or documents from 1990 forward unless a key document was referred to in these later works as foundational to subsequent policy decisions or as influential in how subsequent research was undertaken. Examples of such documents include the Black Report and the Report of the Task Force on Mental Health of Immigrants and Refugees first introduced in Chapter One.

At the outset of the study, literature that provided a historical overview of the Canadian and British health systems was reviewed. The purpose of this review was to identify the general premises upon which the two countries' health care systems were based, to trace the ways health policy decisions were linked to policy positions of the central government and to note how these changed over time. At this point census data from each country were also reviewed to establish the population profiles of the populations of interest. Following this, specific searches were undertaken of several health data bases. I used the Ovid platform which includes CINAHL (Cumulative Index of Nursing and Allied Health Literature) and MEDLINE (Medical Literature Analysis and Retrieval System Online) data

bases to identify literature related to several main areas of work deemed at the time to be central to providing background information on concepts of interest to the study. These included subject searches of empirical and theoretical work using health, health systems, culture and health, migration and health, policy and international comparative policy analysis as key words. Health systems, health policy and international comparative policy analysis citations retrieved were further limited to those that included the UK, Britain and/or Canada and those that did not include the these countries but did address methodological issues. I also undertook a subject search of the King's Fund Library in London as this library has a substantial holding of policy documents and related literature. Key words used included, culture and health, migration and health, gender and health, women's health, immigrant women's health, health policy, international comparisons and after the study data were being analysed; ethnicity and health, health inequalities, equity and health, social capital and health, social cohesion and health, social inclusion and social exclusion. A search of government publications related to health, immigration and health of immigrants for Britain and Canada was also undertaken. To do this I used the internet to access government websites and publications (both commissioned reports and official policy documents) related to health policy and migration and health. Following these searches specific searches using the same data bases but using health inequalities or social determinants of health as key words were also undertaken.

Of note is that while health inequalities yielded numerous government documents in Britain, this was not true of Canada. In Canada, search words that produced documents addressing similar issues were social determinants of health. Similarly, in Canada migration and health or culture and health were key words that tapped into literature of interest whereas in Britain the terms ethnicity or ethnic minority and health were more likely to yield articles of interest.

University library holdings were also searched. These latter sources provided background information on policy initiatives and government documents related to the population of concern that were not available online. The documents reviewed enabled me to locate this research in context by reviewing the history of health policy development and the political and social influences on the health policy context in the UK, Britain and Canada.

The searches of health data bases, particularly CINAHL, generally produced few empirical or theoretical articles addressing migration and health with the exception of a number of publications in Social Science and Medicine. Of these, articles that addressed theoretical issues in research related to social influences on health and articles that were theoretical or empirical and addressed concepts related to health inequalities were also

reviewed. The reviews of the health data bases produced several articles exploring questions related to culture and health or policies influencing the health of cultural or ethnic groups. A number of these are referred to in this review. However, articles that took an expressly culturalist stance, evident by limiting the analysis to the description or exploration of beliefs and values of particular ethnocultural groups, were read and then generally not referred to except to establish that migration and intercultural relationships are ongoing issues in health care.

As there has been considerable theorizing and research using a critical perspective or drawing upon feminist theory related to issues of diversity undertaken in Britain in social science and social policy, social science data bases were also searched. The review of the social science literature focused primarily upon basic writings of key theorists and examples where this work has been drawn upon to address questions of immigrant women's health or to illustrate where the premises or assumptions of this current study aligns with work of other theorists or theoretical traditions. Work of key social theorists who have sought to make sense of individuals' experiences in relation to broader social and societal structures were also read primarily to locate the chosen theoretical perspective in the context of this broader body of work.

Writings of feminist theorists and others whose work, both theoretical and empirical, aligns with the 'post-colonial' project were also reviewed. These writings were drawn upon to illustrate the theoretical issues that must be considered when undertaking an inquiry such as this, to assist me to define the problem of interest in both theoretical and empirical terms and, as was the case with Fiona Williams' writings, to provide a parallel case illustrating the value of critical inquiry that had been undertaken within the social policy arena.

In the final analytic and writing stages of the study, when concepts central to the participants' experiences were identified, additional literature searches were undertaken to enable the development of the conceptual analysis. For example, this study was concerned about first generation immigrant women because earlier work had identified that they faced unique challenges related to settlement and accessing health care services and had documented higher rates of health inequalities over the life course. As relationships with others in the informal sector have been identified in previous work as key resources for women this became the entry concept for exploration. As interviews were conducted the overriding concerns of both mothers and daughters were, in their view; related to processes that interfered with, or limited their ability to establish relationships. These processes were associated with their marginal status within their communities. Marginalization and processes related to it therefore became a central concept of interest.

In the final stages of analysis literature was again reviewed, but this time as 'data'. Taking direction from Smith (1987a,b, 1990) literature that offered explanations for health inequalities and theoretical premises upon which different viewpoints were developed were reviewed and discussed in order to examine the ways the theoretical premises of these discourses aligned with the experiences of the study participants.

This later process of review and analysis is described in greater detail in Chapter 3. In this phase, new policy initiatives that interfaced with the concepts of interest were also examined. One example in Britain is government documents related to the Social Exclusion Unit that discussed health. In addition, as the participants' accounts strongly aligned with writings of particular theorists, such as bhabha and Bourdieu, these authors' writers were also revisited at this time to enable a discussion of the ways the participants' accounts differed from, or extended, their work. This process of incorporating literature into the analysis is in keeping with the methods employed in this study which will be described in the next chapter.

Theoretical & Methodological Premises of Policy Analysis

It was noted in the first chapter that undertaking this research in two countries offered the possibility of drawing attention to the ways social context, as shaped by policy, can influence experience. Prior to undertaking this research in Canada and Britain therefore, I examined the literature to identify models for international studies in health in general and examples that included the UK or Britain and Canada, in particular. Several studies were identified that included comparisons of the UK or Britain with Canada.

Upon reviewing studies that included both countries it was noted that although all have comparative elements, each project had taken a different focus (see for example, Crichton, 1981; Gray, 1991; Twaddle, 1996; Wall, 1996). Some undertook comparisons of market driven or supply driven systems and considered associated population health profiles (Hsiao, 1992; Hsiao & Morone, 1992), others compared the social and political climates of different countries and how these have influenced the way each country's health care health system has developed (Gray, 1991) while others compared how particular programmes are organized in different countries and appraised their impact on specific health outcomes. Still others examined the ideological premises guiding the development of health care systems or shaping health care reform in particular countries, how such premises are reflected in the models of evaluation used and in turn how such data sets are drawn upon to inform health policy decisions (Block, 1997; Twaddle, 1996). None of these studies sought to consider the impact of such initiatives upon particular social groups. Nonetheless I include an overview

of work undertaken in this arena because it offers insight into the types of policy issues of concern internationally and it introduces the British and Canadian policy contexts.

Foltz (1995), writing for the WHO, set out to provide an overview of approaches to international research in health. He observes that much of the policy research that has been undertaken has employed the "rationalist approach" which, while effective in answering some questions, has been less instructive in understanding the processes of policy development or variability in responses to particular policy or programme initiatives across population groups or countries. Further, he notes that while a particular data set may document the incidence of disease or rates of mortality by a region or subset of a population theoretical explanations for such profiles are lacking.

Ovretvert (1997) also provides a comprehensive introduction to international health research. He suggests that the purposes of comparative health policy research are to; "describe policies in different countries and regions which have similar aims or content, describe different policies which have achieved the same aims, or are intended to, compare policy formulation or implementation processes or strategies" (p. 2:10). He offers as an example research on policies to "reduce inequalities in health status and in access to health care between regions or groups" (p. 2:10). Ovretvert advocates for research that critiques or analyses the strengths and limitations as well as goals and resources of different health care systems. He does not however offer direction for how this could be undertaken.

Block (1997) offers direction for structuring international comparative policy studies in an effort to fill evident methodological and knowledge gaps related to health reform initiatives. For example he suggests that comparisons should emphasize the process of reform and include information about the policy process, objectives, or concepts underpinning reform initiatives at the systemic level (i.e. efficiency, equity[3] and quality), institutional processes, and the stage of implementation of reform initiatives. As such, Block (1997) challenges the analyst to examine the evidence of reform both within formal policy documents but also to look for evidence that resources, organizational structures or education

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[2] The term equity holds different meanings in different contexts. For some authors i.e. Dowling (1999) writing in Britain, equity refers to the gap between rich and poor. Lindbladh and colleagues writing in Sweden (1998) refer to equity in health as a goal that stems from the need to address health inequalities or differential health status by income but, they argue, a goal motivated by a desire to maximize the 'common good' (p. 1023) not necessarily individual wellbeing. In Britain the term health inequalities or inequalities are terms associated with the Black Report and Whitehead's Health Divide (see Townsend & Davidson, 1992) and subsequent works examining the correlation between health and social class (MacIntyre, 1997; Walker & Walker, 1997). As such in the British,. context it seems equity and health inequalities are most likely to refer to similar concepts. However, in Canada, equity is a term that most frequently associated with discussions of (equitable) access to health care, work and/or education. It appears this is the way Block (1997) is using the term. For reasons that will be discussed later in this paper in the section on the development of discourses on culture and health, equity, inequality and inequity hold different meanings and as such must be considered in context.

for change initiatives have been planned, undertaken or are in process. He argues that comparative methods are particularly useful for understanding complex problems.

Others share Block's view. For example, in writing about the role of case studies in analysis of health service changes, Keen and Packwood (2000) note "case studies are valuable where policy change is occurring in messy real world settings, and it is important to understand why such interventions succeed or fail.

Of the work identified and reviewed none provided a theoretical basis for framing or undertaking such comparisons. In what follows therefore I turn attention to other theorists' perspectives on policy analysis. A number of analysts focus attention on the premises or assumptions that inform policy decisions as the focus of analysis. For example, most articles reviewed, whether in social or health system and policy analysis, examine the concepts of effectiveness, equity and efficiency (Adeyi, 1998; Block, 1997; Gilson, 1998; Hsiao, 1992; Twaddle, 1996). While others examine the consequences of competing ideologies. Policies informed by the ideology of efficiency competing with policies informed by equity and effectiveness is a frequent example (Twaddle, 1996; Williams & Popay, 1994). Other analysts recognize such values such as individualism, collective responsibility, equality and participation (Block, 1997; Wall, 1996) or goals of universality, equal access and effective use of resources (Hsiao, 1992) as influencing policy discourse. Such ideologies are seen to reflect the political and social agenda of the countries of interest and influence the ways in which health policy is articulated and resources allocated.

Hsiao (1992) is one of a number of analysts who have undertaken international comparisons of the strengths and limitations of a number of approaches to health care financing and service delivery. It is his contention that a key issue in health policy is how a country reconciles the ideological debate between "those who favor free enterprise and those who believe in the merits of government planning as a means of structuring an efficient economy" (Hsiao, 1992, p. 615). The stand taken in this debate ultimately shapes the policy initiatives undertaken. One of the decisions facing health planners and policy makers is:

> "how and by whom scarce health resources are to be allocated among programs, diseases, and regions" (Hsiao, 1992, p. 615).

In addition nations must, Hsiao (1992) argues, "endeavour to obtain maximum efficiency in the production of health services" (p. 615). Britain and Canada are characterized as having taken what Hsiao calls the "supply-side" approach. That is, since health services are necessities for maintaining life and relieving suffering, everyone is entitled to reasonable access to health care, regardless of his or her ability to pay" (Hsiao, 1992, p. 617). They have therefore placed

> "fiscal power in public or quasi-public agencies, which use a political or bargaining process rather than the flawed market to determine a total budget constraint for health care" (p.617).

In Britain the central government uses its budgetary process to assign total expenditures while in Canada the provinces, after having received some funds from the federal government, make budgetary decisions while adhering to federally defined guidelines.

Hsiao (1992) is of the view that the "financing mechanism funded through general revenues, such as that used by Britain and Canada, is the most 'equitable' assuming general revenues are derived largely from progressive income taxes" (p. 621). Hsiao arrives at his conclusion after having compared the health systems of six countries on a number of parameters including: systems of financing and such outcome measures as expenditures, health outcomes, public satisfaction and access. He concludes that:

> "countries that rely on the supply-side approach give their people much greater access to physician services and have lower health expenditures...Overall, all other outcome measures indicate that the US system produces the poorest health outcomes and satisfaction while spending the most" (Hsiao, 1992, p.631).

These comments suggest that Britian and Canada have taken a similar position on a number of issues that play a role in health policy discussions. It therefore can be argued that in general terms these two countries represent a similar case.

A country's perspective on health policy is shaped by the ideological premises of government, the structures of accountability within government and how governments conceptualize and enact their roles in the provision of health services. The literature reviewed above acknowledges that decisions made at the highest levels influence the structures and systems set in place and the allocation of resources, at a more local level. These in turn influence how people at the front line deliver care and how patients, or recipients of care, gain access to and perceive care (Abel-Smith, 1994; Morgan, 1993). None however, considers whose viewpoints are reflected in policy nor do they provide direction for including alternative voices, an issue central to critical inquiry. These are however central concerns for both Smith and Bourdieu and a central interest in this study. Their perspectives are therefore introduced in what follows.

Why Bourdieu and Smith?

While one of Smith's (1987a,b, 1990) interests is the analysis of the role of sociology for its part in the creation of ideological structures, she also sees one goal of research is to make visible organizational structures and 'local' ideologies of the social systems with which we as citizens interact. A central problematic for Smith is that social structures, specialized practices, and the ideologies that underpin them reflect the interests (world view) of those who articulate them. Smith therefore asks, how adequately do such ideologies account for, in her case, women's experiences?

That is, Smith (1987a,b, 1990) argues it is not sufficient to study a phenomenon from the perspective of those most invested (i.e. the health care system from the perspective of health care professionals). It is her position that researchers must also strive to bring the perspective of those whose views are "outside of the frame" into the discourse. This can be done by making other viewpoints visible and by challenging assumptions that are often taken to represent reality. Such "challenging" is taken up when assumptions and the ideologies underpinning them are held out for examination. This form of analysis is necessary if the goal of research is to draw upon experience to inform policy. Smith's perspective aligns with the problem of interest in this research. She also provides a methodology for proceeding with such inquiry.

Bourdieu also links social circumstances and associated societal structures to individuals' experiences. His approach is to gather individual accounts and to use individual cases to illustrate ways societal structures shape experience and to, in turn, gain insights into how individuals make sense of such social processes. He seeks to illustrate individuals' 'logic of practice' (Bourdieu, 1990a; Bourdieu et al, 1999; Bourdieu & Wacquant, 1992).

These two theorists then, offer a means for introducing 'local' voices into policy discourse. In conceptualizing this study I have proposed to examine the question by starting from women's standpoint (Smith, 1987a,b; 1990) and then exploring the ways experiences, in this case women's relationships, are organized by extralocal conditions.

The theoretical position taken in this study assumes a link between experience and broader policy and associated ideological structures. As this premise is central to the perspective of these two theorists I have undertaken a brief review of ways major theorists have theorized the relationship between experience and social structure.

In what follows I provide an overview of how major theorists have problematized the link between 'macro' and individual behaviour or, conversely, where they have placed the emphasis in their work. In creating this overview have drawn upon original work (Berger &

Luckmann, 1966; Cicourel, 1974,1976; Garfinkel, 1973; Geertz, 1983; Giddens, 1974, 1984, 1991, 1993; Schutz, 1970, 1973; Walby 1997) and the work of social theorists who have analysed trends in the development of social theory (Douglas, J. 1970; Douglas, M., 1973; Giddens, 1974, 1997; Ingram, 1987; Taylor, 1999; & Porter, 1998). In an effort to highlight main points of these theorists' work I have summarized the major concepts and theorists associated with them in Diagram 1.

In discussing the main points these theorists' perspectives raise I draw attention to the theoretical tensions that continue to be the focus of considerable debate. In creating this summary I have reduced a history of social theory and conceptualized it as having two main starting points. This means that, of necessity, the work of a number of theorists will have been left out and the many nuances of the work of those theorists who are included do not receive comprehensive attention. Nonetheless, in choosing to draw upon Bourdieu and Smith in this research I have taken the stance that there is a relationship between 'macro', or broader society and its institutions, and 'micro' that is, individuals' experiences. I think it is therefore important to illustrate, even succinctly, the ways this relationship has been conceptualized by other theorists.

The 'macro-micro' debate and the conceptualization of individuals as active or passive agents operating within society has developed over decades of theorizing. As Taylor (1999) observes:

> "Durkheim followed Compte in seeing the focus of sociological inquiry being on the societal structures rather than the individuals who comprise them. However, unlike Comte, he argued that, although sociology dealt with objective facts which could be observed and measured, these 'social facts' were not mere objective *things* but external collective phenomena which were general through society, such as law and religion, and which constrained individual action" (p. 52).

There are a number of theorists who locate their analytic emphasis on the role of social structure. This includes the systems approach conceptualized by Parsons. Some critics have argued that while the systems approach can enable an analysis of the impact of one sector of a system on another it does not afford attention to the perspective of individuals who function within the systems of interest. Systems theory has been credited with other shortcomings. "Critics of functionalism have frequently pointed to its apparent failure to provide an adequate explanation of social change and the related issues of conflict and social struggle" (Taylor, 1999, p. 58).

Diagram 1 Theoretical Positions on Links between Experience and Structure

Study of External Social Structures
– **Macro Sociology** – “”behaviour of people in society is structured according to a set of rules or laws” (Porter, p. 11)

Study of the Active Human Self – Micro-Sociology

Thomas Hobbes 17th century
Philosopher focused on social order. Saw people as individualistic and as agreeing to order if it served them or if coerced by the state.

Emile Durkheim (1920s +
Social Solidarity – societies hold collective values, rules and norms external to individuals. Social interaction leads to the development of a ‘collective consciousness’ as a force that structures the social lives of individuals (Porter, p. 15)

George Herbert Mead 1930s
Social psychology: self in interaction,
Assigning symbolic meaning

Talcott Parsons 1940s +
Articulated systems theory which laid the foundation for role theory, study of individual roles and relationships within organizations & society. Assumes individuals have the moral commitment to ensuring the integrity of society.

Blumer 1960s
Symbolic interactionism:
reciprocity a feature
of social action.

Karl Marx 1940s +
Economic Theory of Production: Focus on collection action and individuals as reflexive agents.

Alfred Schutz 1960s +
Phenomenology: explores the lifeworld. Focus of interest on meanings individuals assign to actions

Goffman 1960s Theorizing Macro-Micro links
Concerned with how links are established, structured and maintained? ‘Talk’ is an avenue for communicating symbolic meanings.

Garfinkel 1960s Ethnomethodology
Explores ways individuals make sense of the social world,
How they grasp rules of social organization (macro); what tacit assumptions about the world are drawn upon & meanings communicated. Takes position that social order not a result of common culture but the practical accomplishments of reflexive agents.

Gramsci 1970s Builds from Marxist
Position on class relations. Examines strategies of the state to sustain power. Hegemony a central concept. Some recognition of individual action but this is located within the broader society.

Frankfurt School 1970s Concerned with social integration & critical theory. Central concepts:
Instrumental rationality –influence of society; Substantive rationality - freedom-justice.
Focuses attention on the individual who is co-opted by broader social processes such as the media (Taylor, 1999).

Habermas 1970s + Draws upon Marxist conceptualization of intergroup relations & conceptualizes individual ‘communicative action’ informed by Weber, Mead, Schutz & Parsons.

Giddens 1970s+ Structuration Theory. Considers the duality of structure & human processes. Society is a product of skilled reflexive agents; Structure is produced & reproduced ‘social practices ordered across time & space”(Giddens, 1984, p. 170). *Rules* create a stable & ordered social life. *Agents* incorporate processes to interact & transform.

On the other hand, those who focussed attention on the individual and emphasised social meaning as the focus of interest were criticised for not locating their view within its social context. There are a number of theorists whose work was generally published in the 1960s and 1970s who explored the processes of assigning meaning and taking action and saw these to be informed or shaped by institutional structures, rules, and practices. The work of Weber, Giddens, Habermas and Goffman has been particularly influential in this regard.

> "Weber argued that society should be conceived primarily in terms of the *meaningful* social action of people. Collectivities such as classes, or bureaucracies do not determine behaviour, but rather exist as modes of 'actual or possible social actions of individual persons' (Taylor, 1999, p. 55).

Taylor further contends that:

> "Weber argued rather than trying to analyse human action from 'outside', sociology has to be based on the interpretative understanding (verstehen) of the meanings that people give to their actions" (p. 55).

Giddens' perspective articulates a position between the 'micro' and 'macro'. His structuration theory assigns social rules and associated structures the role of informing and guiding action.

> "At first sight, it might seem as though micro and macro analysis are distinct from one another. In fact, they are closely connected (Knorr-Cetina & Cicourel, 1981; Giddens, 1984)...Macro analysis is essential if we are to understand the institutional background of everyday life. The ways in which people live their everyday lives are greatly affected by the broader institutional framework...Micro studies are in their turn necessary for illuminating broad institutional patterns. Face-to-face interaction is clearly the main basis of all forms of social organization, no matter how large-scale" (Giddens, 1997, p.85).

Despite these comments, in my reading of Giddens' work, there is a contradiction. That is, he asserts that social structures are not constraints on action. He does not make provisions within this frame for perspectives that disagree with, or hold a different view of, the prevailing social order. That is, despite acknowledging differential power there is no recognition that 'rules' are largely articulated by a taken for granted 'normal' social order (Giddens, 1984, 1991, 1993).

By contrast, these issues are taken up as central concerns of Smith and Bourdieu. It is the taken for granted social order that Smith has argued is largely reflective of the 'male' dominant viewpoint, which eclipses because it doesn't 'see' women's viewpoint. Similarly,

Bourdieu, has drawn attention to the ways in which the social order is reproduced, and therefore sustains intergroup relations which he argues has the effect of privileging one group over another. This observation is also made by Giddens (1997) in commenting upon Bourdieu's contributions. Both Bourdieu and Smith direct attention towards ways individuals or groups challenge, or express dissent against the status quo.

Smith (1987a) has developed a methodology that brings women's perspectives into view. This is accomplished by "taking this experience of mine, this experience of other women, this 'line of fault' and asking how is it organized, how is it determined, and what are the social relations that generate it?" She focuses attention on the ways experiences are socially organized and directs the examiner to consider how adequately ideology accounts for women's experiences. Her method directs the analysis to focus on ideology as the premise underpinning policy.

Smith's stance aligns in many ways with Goffman's exploration of the ways the individual defines and affirms the sense of self through interactions with others. In particular as Porter (1998) observes, Goffman's research in the asylum draws attention to the interaction between structure and individuals' experiences.

> "One of the consequences of entering such an institution is that the normal props of personality, such as freedom of movement...are denied. The patient begins to learn how difficult it is to maintain a conception of oneself as a human individual when the human supports for that conception are removed. Moreover, it is impressed upon the in-patient that she has failed in her life and therefore no longer deserves the status normally accorded adult members of society" (Porter, 1998, p. 93).

Smith's perspective, and Goffman's in some instances, extends beyond experience to understand how such experiences are socially organized.

As suggested by this overview, social relations have been a central concern of sociologists, and many have used the concept of social class to organize such inquiry. More recently others have directed attention towards gender relations (Walby, 1997) or relations between different ethnic groups. These latter perspectives have taken the stance that to focus exclusively on class obscures other social processes operating.

One of the motivations in the development of social theory has been to address the observation "One cannot explain *why* a given action has occurred by appealing to how often it happens. One must also appeal to the intentions of the actor" (Ingram, 1987, p.3). This observation is particularly salient to this present study for while considerable attention has been paid to population based studies of health inequalities, the mechanisms whereby other

social influences exert their effect are not well understood and the views of those experiencing inequalities in health are generally not solicited.

I have located Habermas' (Ingram, 1987) perspective in the centre of the Diagram because my reading of Habermas locates his as a theoretical position that bridges experience and structure. Or as observed by Ingram, (1987) Habermas "reaffirms the phenomenological insight that the environment to which we adapt is already a linguistically articulated world of shared – and to that extent, public and objective -- experience" (p. 20). This theoretical position has the individual continually reconciling experience with broader social structural conditions. However, in Habermas' view structure is accessed through language. While I think Smith would agree language and texts offer insights into structure, the assumption that the structure of language is *shared* is problematized by Smith. That is Smith's view, like Goffman's, is that language and structures are defined by a particular social group, and may not reflect the perspective or experience of those who stand outside of that particular arena.

From this overview it is clear that while some theorists may focus attention on analysing either 'macro' or 'micro' social processes, in recent years the emphasis has shifted towards perspectives that take into account both forms of influence on social systems and individuals' actions. In drawing upon Bourdieu and Smith then, I have adopted the perspective of theorists who recognize that individuals' experiences are shaped, but not determined, by social structures, and that the individual's relationship to structure can be accessed by beginning with their viewpoint and analysing their own 'logic of practice' (Bourdieu, 1990a). Experiences then can be discussed in relation to official texts or discourses such as policies and their theoretical premises (Smith, 1987a,b, 1990).

As this study is concerned with a population group identified as likely to experience inequalities in health it is important to understand how health inequalities have been conceptualized in research and taken up in policy. In what follows therefore I examine perspectives on health inequalities.

Theoretical Perspectives on Health Inequalities

MacIntyre (1997) has traced the interest in health inequalities in the UK to the first national documentation of rates of death by occupation in census data of 1851. Since that time a number of studies have documented a class gradient in health status and noted risks to different subgroups of the population and more recent studies suggest that the health differential between the highest and lowest classes has widened. Variations in health have been noted by age group, by geographic communities, by labour force participation and by gender.

The Black Report (Black et al, 1992, Britain, 1980), a key study documenting inequalities in health by social class, has prompted considerable research and debate worldwide. The authors of this report posited 4 explanations for the documented disparities in health status among different sectors of the population. "1. Artefact Explanations 2. Theories of natural or social selection 3. Materialist or structuralist explanations. 4. Cultural/behavioural explanations" (Black, et al., 1992, p. 104). Since that time evidence to support or refute each of these explanations has mounted and alternative explanations have been put forward by scientists throughout the world.

Each explanation is premised upon different sets of assumptions about conditions that contribute to patterns of illness and the roles of individuals, governments and health systems in this enterprise. Each explanation offers direction for different policy responses with implications for cost. Additionally however, assuming there is evidence to support a particular perspective and evidence to suggest issues could be effectively addressed the decision to act upon such evidence at the policy level assumes a compatibility of ideology between the premises of the explanation, and the policy stance of the government.

Since the Black Report a number of other studies and analyses of the four explanations have been undertaken in Britain and elsewhere, and new variations of these explanations have been introduced (Evans, Barer, Marmor,1994; Gordon, et al,1999; Haan, Kaplan & Camacho, 1987; MacIntyre, 1997; Marmot, Ryff, Bumpass, Shipley & Marks, 1997; Nazroo & Davey Smith, 2001; Whitehead, 1992). Two comprehensive follow up studies were commissioned by the British government. The first of these was a study generally referred to as the Health Divide undertaken by Margaret Whitehead (Whitehead, 1992), the second is the Independent Inquiry into Inequalities in Health often referred to as the Acheson Report published in 1998 (Britain, DoH, 1998, a,b). The research that formed the basis of this latter inquiry was published in a separate document (Gordon, Shaw, Dorling & Davey Smith, 1999).

The 'Health Divide' was commissioned to "draw together the wide ranging new evidence and to describe what had happened and could happen, in policy development" (Whitehead, 1992, p. 221). Whitehead drew upon evidence gathered in the decade following the Black Report and incorporated findings of work that had established a clear link between employment status and health. She concluded studies in Britain since 1980 have provided "the clearest evidence yet of unemployment being the cause of poorer health" (p. 256) and "that unemployment can cause a deterioration in mental health" (p. 256).

Whitehead also explored links between ethnicity and health. While she acknowledged the problems posed by the way data related to ethnicity or 'race' were being recorded she recognized that a disproportionate number of ethnic minorities and single

parents were facing poverty. So she, like others, argued it is important to examine ways deprivation exerts its effect. Notwithstanding the measurement challenges and the variability of indicators used in the studies examined, Whitehead concluded that there is:

> "convincing evidence of a widening of health inequalities between social groups in post-war decades ...in some respects the health of the lower occupational classes has actually deteriorated against the background of a general improvement in the population as a whole" (Whitehead, 1992, p. 275).

In what follows I examine the four initial explanations of health inequalities and introduce additional explanations that have been offered to account for differential health status. The work I draw upon includes the work of researchers who employ different terms such as social determinants of health or social environment and health to describe differential health status of population groups. The majority of this work has its origins in North America.

An ongoing challenge of comparing evidence across studies is that approaches to measurement have not been constant. For example, categorizations of social class have been refined. Such refinements include appraisals of neighbourhood deprivation or assets based measures as alternatives to social or occupational class. Some have used alternative social classifications for women such as level of educational attainment, in lieu of categorizing women according to their husband's occupation as was done in Black's original study. Additionally, study designs are not all comparable. Some examine data gathered over time in longitudinal designs, while others have taken a cross sectional approach. These issues have been examined in detail by MacIntyre (1997) who in her review suggests that while some explanations have garnered increased support the four explanations need further refining in part because emerging evidence suggests they are not all mutually exclusive. MacIntyre also draws attention to "the polarisation and politicisation not only of the policy response to the Black Report, but also of the academic response" (1997, p. 732). Recognizing these caveats, the analysis of literature that follows will report trends and raise conceptual issues.

Are there inequalities in health?

Here I introduce the key works that address issues of health inequalities in general and health inequalities of women and ethnic minorities in particular. The first question that must be addressed however is, is there evidence of inequalities in health? There is overwhelming evidence to suggest that the answer to this question is yes (Arber, 1997; Benzeval & Donald, 1998; Black, et al, 1992; Evans et al, 1994; Gordon etal, 1999; Marmot et al,

1997; Nazroo, 1999; Nazroo & Davey Smith, 2001; Robinson & Elkan, 1996; Britain, DoH, 1998a,b; Whitehead, 1992; Wilkinson, 1994,1996, 1999). Although, as noted above there are variations in the magnitude of difference in rates of disease or mortality between social groups, depending upon the measures used. MacIntyre (1997) observes:

> "using different measures of SES has helped to clarify the relationship between various SES indicators and a range of health measures, and has shown that observed inequalities are consistently found whatever the measure used, the magnitude of these differentials depending on the SES measure used" (p. 733).

By answering this question in the affirmative the *artefactual explanation* is not supported. That is, the prevailing evidence supports the view that there are 'real' inequalities in health. "The continuation of inequalities in health is not an artefact, cannot be explained away by social selection, and is not solely attributable to individual behaviours" (MacIntyre, 1997, p.729).

Theories of ***natural or social selection*** represent Black and colleagues' second explanation for observed inequalities. The general premise of this explanation is that persons with poorer health have a limited ability to participate in the work force and therefore have a lower social standing. Robinson and Elkan (1996) refer to this explanation as 'social or selective drift'. That is, "ill-health causes people to be downwardly socially mobile - to drift into the lower social classes" (p. 92). While there is evidence that some health conditions are hereditary and can be identified through increasingly sophisticated screening measures that now includes DNA (deoxyribonucleic acid) analysis these do not account for the profiles seen. Nazroo (1999) is one researcher who has explored this explanation with respect to 'race' and while he concedes that there are some biological influences the statistics suggest that the *material structural* explanations have more support.

As Nazroo explains the ***natural selection*** explanation is premised upon the assumption that patterns of illness accrue from genetic or hereditary tendencies with consequent limitations on the ability to participate in the workforce in ways comparable to the general population. There is some evidence to support the natural selection explanation as, for example, some population groups may be predisposed to illnesses such as Sickle Cell disease. However, Nazroo (1999) examined UK data and concluded that such biological predispositions make a very small contribution to the documented patterns of health inequalities. He concludes there is much stronger evidence to suggest that characteristics of the social environment produce the strongest effects on patterns seen.

Marmot and Wilkinson (1999) weighed the evidence in support of those who argue health inequalities are explained by a population group's genetic predisposition to illness rather than as a consequence of environmental influences. Their research demonstrates that there is a significant decline in health status subsequent to migration and that the disease profile follows the disease profile of the host country not the country of origin. They also conclude it is not an inherent predisposition to particular diseases that accounts for the profiles seen.

A number of other analysts have examined data related to ethnicity, migration and health status in an effort to gather evidence related to popular notions that immigrants consume more health care services than their Canadian or British born counterparts. A number of studies in Canada and Britain concur with Marmot and Wilkinson's (1999) findings that, upon migration, immigrants' health is better than their Canadian or British born counterparts, but declines with time to reach similar levels as the general population (Abel-Smith, 1994; Chen, Ng & Wilkins, 1996; Marmot & Wilkinson, 1999; Parakulam, Krishnan & Odynak, 1992). Other explanations are offered to account for this change in health status.

Because there is an overrepresentation of people of colour in the lower echelons of the workforce and in the lower social classes, some researchers have proposed that it is material deprivation as a consequence of, and/or in conjunction with, *racializing practices or racism* that accounts for health inequalities. This evidence lends support to the third explanation that health inequalities are a consequence of ***material or structural*** conditions. It also introduces the possibility that health inequalities may be associated with *cultural behavioural* issues, at the societal level.

Marmot and colleagues (Marmot et al, 1993) undertook a comparison of three different population based studies undertaken in the UK and the US with three different population groups in order to examine three different explanations of health inequalities (i.e. indirect selection, health selection, and social causation). The studies employed four different measures of health that have been shown to have a clear inverse relationship with socio-economic status. These were self-perceived health status, depression, a measure of psychological well-being and smoking. They employed a multivariate model that used both education and occupation as indices of status. In their view education was a better measure of social status likely because of the precision of the tools used.

These authors concluded that:

> "there is worse health among those at the bottom of the socioeconomic distribution than those at the top. This is consistent with a link between poverty and ill health. Perhaps more important, all three studies show a social gradient that runs right

> across the whole population: the lower the social status the greater the physical and mental ill health and the worse the psychological well being" (Marmot, et al, 1997, p. 905).

These authors argue that there are characteristics of the social environment and health behaviour that can mediate these observed effects and that these may be somewhat different at each end of the spectrum. They therefore argue that "converging evidence suggests that attention must be paid to the circumstances in which people live and work" (p. 908). Their stance was that "health is related to social position rather than to individual characteristics of individuals who end up in different strata of society" (Marmot et al, p. 905). Their research therefore lends greater support to the social structural explanation than natural selection and draws attention to the need to examine cultural behavioural influences on health inequalities.

Research continues to provide a range of evidence to support the *material structural* explanation. For example, greater associations between poverty, poorer material living conditions and gender (Arber, 1997; Arber & Cooper, 2000) and ethnicity (Nazroo, 1999) have been documented.

Still other researchers have focussed attention on inequalities in mental health (Dowhenrend, et al, 1992; Kuh et al, 2002). In the UK, Power and colleagues, designed a study to assess whether inequalities in psychological status were better explained by health selection or social causation. These researchers "used data from the 1958 British birth cohort, followed over three decades, to identify causes of inequality in adulthood" (Power et al, 2002, p. 1989). They too concluded that health selection failed to account for health differences arguing rather that the data suggest a "predominant role for social causation" (p. 2000). Life factors accounted for variances in mental health seen, notably "stronger effects for work factors for men ....and early child-bearing and financial hardship for women" (p. 1989). In addition they noted that gradients of distress were cumulative from childhood. These authors concluded that for mental health, as measured by the Malaise Inventory, the evidence supports the *social causation* explanation for inequalities rather than the health selection explanation. While these researchers noted that women's circumstances placed them at higher risk they did not break down the populations by ethnicity.

Davey Smith (1999) focussed attention on the influences of early childhood on health inequalities noting that in Britain in 1993-4 approximately 33 percent of children were living in poverty with many of these in lone parent families. It is his contention that experiences of hardship in childhood and adulthood are cumulative but that there will be variations. He concludes "lifetime experiences of economic hardship will differ between the highest and middle income groups" (Davey Smith, 1999, p. 74) because many in middle income groups

will have experienced deprivation earlier in life. It is Davey Smith's view that childhood and adulthood social circumstances make independent contributions to the risk of dying. He considers the possibility of cumulative effect if material deprivation is combined with negative social conditions like job uncertainty. This underscores the importance of including children in research.

With general agreement that social environment or material conditions do have an influence on health inequalities, the focus of research has shifted to answer questions about the mechanisms whereby social conditions exert their effect. Or, as noted by Marmot and Wilkinson (1999)

> "by understanding how the social environment affects health, its specific features and pathways, it is potentially possible to affect these with consequent impact on health...and...that specific social determinants of health can be characterized and their separate effects on health studied" (p.2).

Other Influences on Health Inequalities

Some researchers have sought to understand influences on educational attainment and psychosocial adjustment through childhood as predictors of social standing in later life. For example, researchers in the UK, drawing upon the 1970 Birth Cohort Study, documented that those without educational qualifications were four times more likely to have poor health and that there was an inverse relationship between depression and educational qualifications (Whitty, Aggleton Gamaraikow & Tyrer, 1999).

Sacker, Schoon and Bartley (2002) drew upon data gathered at ages 7, 11 and 16, in the National Child Development Study that followed the 98% of the entire birth cohort born during one week in 1958, in England, Scotland and Wales. These authors refuted the theory that the impact of social deprivation leveled off in early childhood and concluded that, "at age 16, material deprivation was the strongest determinant of psychosocial adjustment while school composition was most strongly related to educational attainment" (p. 863). Again, these authors did not examine the data by ethnicity.

Researchers in the Ukraine, a society in political and economic transition, explored determinants of self-perceived health and concluded that of the 1700 participants enrolled in their study, women are at increased risk of poor self-rated health than men (Gilmore, McKee & Rose, 2002). They attributed the gender difference to differences in living conditions as in the population studied the majority of women were living in villages whereas men were living in cities. Additionally, of the conditions linked to poorer health status in this study,

poor material situations and low control over life were independently and positively associated with poorer health.

Focus on Processes that Contribute to Health Inequalities

These studies have been able to document associations between particular conditions (poverty, gender, 'race' or ethnicity) and in some cases to trace effects over time. However they generally do not provide us with insights into the processes that contribute to the poorer health outcomes. That is, they do not help us to fully understand why women or why persons of colour would face poorer health over the life course.

Nazroo and colleagues have undertaken a number of studies in Britain in an effort to argue that health inequalities are related to material conditions but also to illustrate that persons of colour are more likely to be living in poorer material conditions (Nazroo, 1999; Karlsen, Nazroo & Stephenson, 2002; Nazroo & Davey Smith, 2001). In his writing Nazroo makes the case for including ethnic categorizations in studies on inequalities in health and in monitoring health services utilization in order to better understand what kinds of initiatives are needed. This notwithstanding, Nazroo's writing draws attention to the difficulties associated with the measurement of ethnicity. These include the consequences of having to distinguish oneself as 'different' and using data categorizations that may not be comparable. Such situations arise when people are asked to identify themselves by ethnic origins, colour, or country of birth.

So, while there are theorists who seek to show that some sectors of the population are more vulnerable to health inequalities, others argue that structuring studies to analyse the health of different ethnic minorities can contribute to the racializing practices that make such groups vulnerable.

> "Neither position disputes that health experience is determined by factors associated with ethnicity rather than ethnicity itself. However, the danger…is that a focus on ethnicity rather than these associated factors can lead easily to the inference that it is ethnicity itself which causes poor health" (Smaje, 1995, p. 15).

Hall (1996a) presents the case against categorizing because it formalizes a process of 'othering' that essentializes individuals. One aspect of his argument is that such data has been used to socially construct groups or create 'unitary' identities for groups. He argues that it is erroneous to assume that because "essentialism has been deconstructed *theoretically*, therefore it has been displaced *politically*" (Hall, 1996a, p. 249). He argues against the

production of 'data' that allows for the continuation of representations of 'us' and 'them' the 'majority' or 'minority'.

Stubbs, (1993) also writing in Britain, makes the case for a critical appraisal of approaches employed by researchers to construct Black people's problems. Such a critical appraisal he contends must be a part of the research agenda. He makes the case for recognizing differences within Black populations in order to accomplish what Ahmad (1993) sets out as the goal "to transform the racialized inequities in social relationships between black and white people which are at the base of racial health inequalities" (p. 3). Further, it is Stubb's (1993) contention that such inequalities structure Black people's interaction with health services.

Smaje (1995) observes that the situations faced by minority ethnic groups in Britian are created largely through the ways immigration policy has interacted with social security policy, a 'racial' division of labour and a tendency to live in inner city areas because of need to access both work and housing. Having reviewed the evidence prior to writing in 1995 Smaje contends that there is considerable evidence of direct and indirect discrimination against people from minority ethnic groups in social security. In addition, he notes that in Britain a disproportionate number of people from minority ethnic populations experience poverty and work in low-paid occupations with poor working conditions (Smaje, 1995). Smaje's analysis supports the material structural explanation of health inequalities but also introduces thoughts on the ways these are experienced.

There is considerable agreement that concepts of 'race' and 'ethnicity' should not be used without critical reflection (bhabha, 1994; Hall, 1996a,b; Hillier & Kelleher, 1996; Kelleher, 1996; Smaje, 1995).

As Smaje (1995) summarizes the history of such terminology he also draws attention to some of the problems it has created and the myths it has perpetuated.

> "Phenotypic difference is just one of the characteristics which people can use to differentiate themselves from others, albeit a particularly powerful one. Although, for historical reasons, current ethnic distinctions in Britain are strongly identified with an ideology of 'race' which considers physical appearance - and particularly skin colour - as the fundamental marker of identity, distinctions have also been made around language, religion, and historical or territorial identity, as well as more diffuse notions such as culture" (Smaje, 1995, p. 14).

In addition to ignoring political and social factors that have contributed to their creation it is argued ethnicity is a label that is generally viewed as a substitute for 'race'. As

such, each is problematic. What is at issue for researchers however is that although these terms may be arbitrary, "the circumstances in which they are used are not" (Smaje, 1995, p. 15). So, while we may challenge the ways in which researchers have arrived at the decision to use particular categories, or to define inclusion within a category in a particular way, other researchers have argued that unless we have such data the real issues of racialization that people are facing will not be made visible. There are therefore a number of proponents for including ethnicity as a category in health research (Nazroo, 1999; Nazroo & Davey Smith, 2001; Kelleher, 1996).

Shaw and colleagues (1999) have documented a persistence of inequalities among second generation ethnic minorities in Britain. These authors document an over representation of people of colour in the lower echelons of the labour force. To a lesser degree a similar pattern has also been documented in Canada (BC, 1998).

These population based studies on health inequalities were among the first to draw attention to the complexities associated with efforts to document 'race' particularly in second and third generations where the impact of being visibly different may be felt but difficult to document statistically. They provide examples of the ways in which such effects may accrue.

> "It is on the basis of success or the lack of it at school that children are selected for manual and non-manual work and, as we have seen, this occupational distinction plays an important part in measured health status differentials. The working class child is rendered at a particular disadvantage on account of these differences because of the fit... The outcome of this is that children from middle-class homes...leave school with a greater facility to manipulate their social and economic environment (which of course includes health services) to personal advantage" (Townsend & Davidson, 1992, p. 113).

This process of cumulative disadvantage has been examined more recently by Reay (1998a,b), in her research into mothers' roles in their children's education. Reay, whose research drew upon Bourdieu's theoretical position, observed that working class mothers and first generation immigrant mothers were unfamiliar with the British system of education and as such, unlike their professionally educated counterparts, could not readily participate in enabling their children's education.

It is Nazroo and Davey Smith's (2001) contention that soci-economic position is a more important determinant of mortality differentials between Black and white than biological or behavioural factors. Having made these observations these analysts argue that

an examination of factors underlying these patterns is needed. They note the mounting evidence that such health disparities are the result of institutional racism and can accrue from associated forms of harassment and disadvantage. These can, as has been argued by others, lead to exclusion with limits being placed on access to housing and education. These authors also draw attention to the need to examine the ways social conditions intersect with, and contribute to, shaping identity.

The issue of *access, or lack of access,* to health services is offered as an additional explanation for health inequalities. That accessibility or inequitable allocation of health services as a factor contributing to, or magnifying, health inequalities is a position advanced by a number of authors in Britian including Nazroo (1999), Benzeval (1999) and Robinson and Elkan (1996). These writers have illustrated the consequences of lack of access to illness care and propose that if resources were allocated more equitably, to match needs with services, morbidity and mortality could be reduced. There are some authors who contend however, that the assumption that inequalities in health are secondary to inequalities in medical care is not necessarily valid (Marmot & Wilkinson, 1999). While in some instances inadequate or inaccessible health care can contribute to inequalities in health a number of authors caution that it is not a lack of *medical* care per se that creates the predisposition to illness. This explanation therefore is best viewed as an adjunct to other measures.

As equity is a principle that must be upheld in Canada's national system, a number of analyses have directed attention at the health consequences of the inequitable allocation of health resources or ways structural or material inequities are manifest in health (Brownell, Roos & Burchill, 1999; Grad, 1999; Lynam, et al, 2003).

The *cultural behavioural* explanation of health inequalities has received considerable attention. One researcher who has sought to examine health beliefs and how these are communicated across generations is Mildred Blaxter. Her work has focussed on intergenerational transmission of health beliefs and practices from 3 generations of mothers of daughters living in poor neighbourhoods of Scotland (Blaxter & Paterson,1982). She seeks to understand the ways people themselves make sense of health and illness (1990) and explored peoples' conceptions of reasons for health inequalities (Blaxter, 1997). She concludes that there are multiple influences upon peoples' understandings of health which include the restriction on choice when people have few material resources to draw upon. She also notes that while some participants had limited or inaccurate information about health, when it was made accessible to them, they were prepared to consider and act upon it. Blaxter (1997) observed that despite epidemiological evidence of links between poor material

circumstances and health, people in her research generally did not see poverty as causing poor health. Rather, people saw poverty as interfering with choices and options.

A number of other analysts have sought to understand health beliefs and practices of the general population or of cultural groups within the population (Kelleher & Hillier, 1996). While recognizing the issues associated with categorizing individuals and groups by ethnic or cultural designations, these writers also make the case that ethnic communities can offer sources of connection. Therefore research that documents the ethnicity of participants can usefully identify health or illness profiles requiring attention and potential resources available to them.

Pathways to Health and Illness?

While there is evidence that supports some explanations for health inequalities more than others and evidence to suggest that several factors may make concurrent contributions to health inequalities, this review suggests alternative research approaches are required to gain insight into the mechanisms or pathways whereby health inequalities are created.

MacIntyre (1997) contends there is evidence to suggest that the explanations are not fully discrete although evidence to support the material explanation is more substantial and argues that each perspective contributes different forms of information to our understanding. She notes however:

> "the issue is thus not 'is it material circumstances or behaviours which determine inequalities in health?' but, 'how do material conditions/social structural position shape particular clusters of health promoting or health damaging behaviours and the health effects of these behaviours?'" (p. 739).

She suggests therefore that it is time to examine the "pathways by which social inequalities in health are generated and maintained in particular contexts" (p. 740).

MacIntyre's (1997) analysis suggests it is not simply material capital that creates the profiles, rather it is the ways these intersect with features of the social environment. I take this to mean that undertaking research that explores in depth the ways material deprivation may be experienced on a day to day basis could offer insights into the complex processes that contribute to health inequalities.

Wilkinson's (1996) research and theoretical work extends the material structural explanation and focuses attention on rates of *relative poverty* as critical factors contributing to the creation of health inequalities. Using 1981 data he documents that persons living in poverty in the UK have a lower life expectancy than those in Canada. It is Wilkinson's contention that it is the relative gap between rich and poor that is most important. That is,

societies with a relatively narrow gap (i.e. Canada) have generally higher rates of wellness whereas societies with a greater gap between rich and poor have higher rates of mortality and morbidity among the poor.

In later work Wilkinson (1999) further elaborated his income inequality explanation. He drew upon data related to economic indicators, health status indicators and social indicators from a number of countries. His analysis showed that a greater Gross National Product (GNP) or economic productivity of a country per capita, is associated with an increased life expectancy. He suggested this was likely a consequence of lower illness rates and better nutrition. However this 'trickle down' argument was not supported by the UK experience. The data there suggested that in the UK context although the general economy improved, the health status of the poor did not.

Wilkinson (1999) also noted that higher rates of literacy within a population were associated with better health status. In this publication Wilkinson (1999) puts forward the view that income inequality is an indicator of a 'fragmented society' and proposes that such societies are characterised by an erosion of social capital or unsustainable development. In keeping with this explanation he argues that literacy rates are indicative of a county's investment in the development of human capital and argues it is this phenomenon, the valuing of, and investment in, persons that contributes to better health outcomes. Although Bourdieu has not examined questions related to health, Wilkinson's explanation aligns with Bourdieu's characterization of society and relationships within it.

As suggested above, each analytic perspective suggests different policy options. Marmot and Wilkinson (1999) presented a review of the evidence supporting different explanations of inequalities and the evidence that particular policy options could positively impact the observed patterns as a strategy towards involving the public and policy makers in exploring options. It is important to note that these authors reiterated, as have many others, that there has been a persistence in social gradients in mortality from all causes. They draw upon the evidence from the "Whitehall studies" which gathered data over a 25 year period from civil service employees in Britain. This study showed health status varied with occupational status and while it was limited to persons employed in office roles within the government, there was much greater control over the measure of social class than that of other studies, because criteria for categorization were clearly defined by the government's own classification system.

Gender and Health Inequalities: Mediating Access to Resources?

Women's experiences of poverty and single parenthood and their influence on health have been the focus of a number of authors' work. Graham's (1993) research in Britain details the nature of the day to day challenges faced by mothers experiencing different forms of hardship. Her work identifies the ways in which experiences are shaped in part by the ongoing nature of parenting but also by the constraints imposed when such work is being undertaken with limited material resources. Her analysis considers the ways in which housing, employment, health and child care policies influence women's abilities to manage.

In subsequent work Graham (2000; 2002) turns her attention to the ways in which women's and men's experiences are gendered and argues that these differences contribute to inequalities in health. She has turned the "spotlight on socio-economic inequalities in health among men and women and the wider inequalities in life chances and living standards which underlie them" (Graham, 2000, p. 170). Her writing also begins to tease out the methodological complexities of seeking to understand the ways in which disadvantage is lived by men and women and the challenges of tracing these to health status.

She draws on her own work and that of other researchers to illustrate the ways in which material conditions influence access to resources.

> "Studies of women's experiences of caring on a low income have described how shortage of money restricts their access to social support and how, without the material support of family and friends, it is hard (if not impossible) to feed the family and meet other health needs " (Graham, 2000, p. 102).

Graham goes on to observe that the ways in which such day to day demands manifest themselves in health outcomes.

> "The distribution of positive and negative influences on health is patterned by socio-economic status and gender. In different ways and to varying degrees, access to health promoting material, psychosocial and behavioural resources increases in line with increasing socio-economic status, for both men and women." (Graham, 2000, p. 102).

Stroik and Jensen (1999) synthesised findings from a programme of research undertaken to make policy recommendations for young children in Canada. As a point of departure they appraised the status of Canada's children in comparison to those in countries with similar and different policies. To do this they drew upon Phipps' (1999) research comparing child outcomes in Canada, Netherlands, Norway, Britain and US. Rates of

poverty in families headed by lone mothers in Britain and Canada are reported to be comparable with Britain somewhat higher at 46 per cent versus 43 per cent in Canada (Stroik & Jensen, 1999). In this regard these authors note "in all countries studied, children in lone-mother families also have worse outcomes than children in two parent families in terms of almost all outcomes that can be measured (p. 56). They observe that: "those countries who pursue a more universal approach to policy and programme delivery have superior record related to child outcomes than countries that target support to certain groups (Stroik & Jensen, 1999, p. 57).

Graham (1993) notes that in 1991 in Britain "around one in ten children with a parent in full-time work live in households with incomes below 50 per cent of average income. Among children cared for by a lone mother... around seven in ten are growing up in households below this" (p. 11). Graham (1993) notes that Black families are more likely to be poor.

Canada and Britain are viewed in Stroik and Jensen's (1999) analysis to have similar degrees of commitment to universal programmes. By contrast the US, whose social and health care systems are based on a market model and who spend a considerably higher percentage of their GDP on health care (Abel-Smith, 1994) have the highest rate of income inequality, the highest rate of lone mother families living in poverty and the highest rate of infant mortality of the 5 countries in Phipp's study.

Both Britain and Canada have similar rates of infant mortality and although such data offer a point of comparison between virtually all countries and are an important indicator of the quality of general health services delivery they reveal little about profiles of children's health. In their study Stroik and Jensen (1999) also sought to appraise the broader health status of children by drawing upon national data sets designed to create child health profiles in each country. They noted that while parents in each of the countries included in their research generally appraised their children as healthy, additional measures used indicated that many children had recurrent health problems and extensive sources of worry.

The studies cited above draw attention to particular groups within society that appear to be more vulnerable to inequalities in health. While a number of population based studies, and general surveys have been undertaken, there are still gaps in our understanding of the ways these conditions exert their effect. Graham's work stands as one example of qualitative work that attempts to illustrate the ways material and social circumstances of the lives of poor women can have an impact upon health.

While MacIntyre (1997) reports that adolescents and young adults demonstrate less evidence of health inequalities than other population groups in Britain, there is evidence from

other studies of different forms of negative impact. For example, British statistics document substantially increased risks of school leaving, and high rates of teen pregnancy for youth in poor and single mother headed families (Britain, 1999, July).

Additionally other authors have noted that there is a gender gap evident in health inequalities. While it must be acknowledged that First Nations' communities face considerable health inequalities in Canada, it would appear that health inequalities are more pronounced in poor communities in Britain than in Canada (Britain, 1999; BC, 1996). The Working Group on Poverty (BC, 1998) noted in their report generally comparable levels of unemployment between Canada and Britain. They also noted however in both countries youth had a rate of unemployment that was almost double that of the general population (BC, 1998). This is an area that requires further exploration for, these data suggest, that the impact of social conditions, including exclusion, on youth are manifest in ways other than morbidity and mortality.

These studies suggest that Canada and Britain have made similar commitments to universal health care and social services. In addition, children in Britain and Canada have similar health profiles when compared on selected indicators and, on a number of measures, fare considerably better than children in countries without universal systems. But by adolescence a pattern of difference begins to emerge and accelerates with Canadian teens faring somewhat better than their British counterparts.

The majority of the studies on health inequalities cited here have employed population based research designs. While such studies have the advantage of documenting population profiles it is difficult with such studies to assess the ways in which factors identified as aligned with health inequalities exert their effect. Knowing the profiles of populations at risk such research can be complemented by research that employs methods that enables such questions be examined in greater depth and from the perspective of those experiencing the issues of concern.

A number of authors make the case that health and social policy play an important role in shaping people's experiences by defining the nature of resources available and by creating the structures that influence access and availability (Graham, 1993, 2000; MacIntyre, 1997; Marmot & Wilkinson, 1999; Williams, 1989; 1996; Shaw et. al., 1999). In what follows, therefore, I provide an overview of the health policy context of Britain and Canada. In so doing I build from the stated similarities and note differences in structure and the ways in which stated ideological premises have been enacted as governments have changed over time. This review provides a background for the analysis to be undertaken later in the thesis.

Health and the Policy Agenda - Britain

As in Canada, Britain's NHS has changed in response to changing government priorities. Kingdom (1996) observes the post war years were important for the NHS in Britain and a period when the goals of universality, free accessibility and comprehensiveness were affirmed. While these premises were foundational they were perceived to be under threat in later years.

Other analysts have observed that despite its claims of universality from the outset some groups have been left off of the health and social policy agenda. Williams (1996) is one of several analysts who level a critique at the tendency for social welfare theory to 'whiteout' or disregard the colour and gender of the poor. "Where 'race' is brought in, it is often, like gender, as a discrete issue, a dimension of inequality, an 'ethnic' or 'minority' group, a group with ' special needs'" (Williams, 1996, p. 49). She takes the position that historically race has been ignored within British Social Policy and the consequences are felt throughout the formal system and broader community.

> "The exploitation of unskilled and low-paid work after the Second World War, of men and women from the New Commonwealth went largely unquestioned ..... Official, bureaucratic attitudes meant that the new immigrants' access to welfare provision - particularly housing and education - was not planned for and, by implication, was presumed not to exist" (Williams, 1996 p. 51).

Similarly Oakley (1994) has taken the position that although the NHS had been founded on an ideology of universality during the 1950s and 1960s, this premise was eroded. The observed erosion coincided with a mounting concern about cost.

She also challenges the notion that the services of NHS were universally available from the outset.

> "Men, women, black people and white people, constitute other kinds of classes with their own distinct locations in the relation of production and reproduction. A welfare state based simply on notions of economic class will provide an inadequate challenge to gender and ethnic discrimination, moreover, forms of institutionalized welfare provision may be inappropriate to the needs of women, black people and other social minorities" (Oakley, 1994, p. 7).

As such Oakley takes the position that policy has created the social conditions that shape particular groups' social standing and influence their access to resources.

This aligns with the official response to the evidence produced by the Black Report. Even though health inequalities were documented, the domain of intervention was deemed to be outside the purview of the NHS for the issues were conceptualized as social not health. Additionally, and perhaps more importantly from a policy perspective, the recommendations conflicted with the ideology of the government of the time, that of individual responsibility for well being and that the health of the state was measured by the strength of the economy. As such, acting upon the report's recommendations would have meant a reversal of the Conservative government's stated aims.

For the purposes of this study however, the Black Report substantiated links between class and health but embedded within this message was documentation that there was a link between 'race' and health. As the authors noted:

> "The pattern of social and economic disadvantage experienced by black Britons is connected with occupational class and is reflected in the working of the labour market" (Townsend & Davidson, 1992, p. 50).

While clear links can be made between government ideology and economic policy it has also been argued that the justification for such decisions was based upon a philosophy of individualism and cultural politics that pitted some groups against others. For example Williams (1996) argued that in this era of neo-conservatism Blacks were portrayed as a threat to national unity. She draws upon the work of a number of writers she considers represent the neo-conservative perspective to illustrate the climate such a view created.

> " The themes of British 'nation' and 'culture' have been harnessed to an explanation of economic crisis with moral and political dimensions, in which the presence of Black people threatens national unity. Black cultures threaten British culture and Black youth threaten social stability and British democracy. Black communities, cultures and families are thus seen as pathological, bringing upon themselves the poverty and unemployment and racial violence they endure. These ideas pick up on 'common-sense' racism and are threaded into a justification for racist policies" (Williams, 1996, p. 90).

What is noticeably lacking in health research in the era of restraint during Conservative rule in Britain however, are observations about what groups comprise those living in poverty and experiencing poor health. While women, particularly single mothers are acknowledged, few studies have drawn attention to the fact that people of colour are substantially over represented in the population living in poverty. While there was little research into these issues by health professionals in

Britain in this time period, there was considerable research being undertaken by British social scientists. These scholars documented the over representation of blacks and visible minority groups in the lower classes, introduced alternative explanations for the associations between poverty and poor health and social standing and called attention to the need for social reform in Britain.

Williams (1996) attributes such oversights to the lack of recognition of the root causes and persistent effects of inequalities. William's analysis reviews the history of colonization and the development of health and social services. In doing so she recognizes that decisions are made in a particular historical context. Such decisions and the practices associated with them shape and influence subsequent initiatives in policy and theory development. Williams (1996) undertakes a critique of the assumptions underlying social policies of Britain and argues the tendency by analysts to overlook the shortcomings of the social welfare system are rooted in the ideological premises of welfare theory. She observes that treating everyone equally without regard for pre-existing inequalities simply maintains the status quo and inhibits an "understanding of oppression - racial or sexual" (p. 53).

Williams' (1996) critique recognizes the links between social well being and health and draws parallels between the premises underlying the systems of health and welfare. It is her position that there is a need for equitable initiatives within the NHS if progress is to be made in addressing inequalities.

Williams' analysis of the status quo in the social welfare system in Britain seeks to consider the ways in which peoples' experiences are shaped by both race and gender. In so doing she draws upon numerous examples to illustrate how such experiences are socially organized and sustained through representations of women or people of Colour within the system. She makes the case that it is these (mis)representations that characterize women in general but women of Colour in particular in ways that that go unchallenged that have perpetuated the disadvantages faced by Black women. She also notes similar shortcomings extend to feminism which she argues has "over-generalised the concept of patriarchy and therefore failed to recognize the far greater significance (at times) of other forms of oppression" (Williams, 1996, p. 61).

Additionally, however, Williams makes the case that women can experience multiple forms of oppression and that for many women, gender is not the only issue determining their social location.

> "Though racism and sexism are both forms of oppression...the simultaneous experience for Black women of racism and sexism not only compounds the oppression, but reconstitutes it" (Williams, 1996, p. 58).

Williams' work draws attention to the need for theoretical positions that are not reductionistic but rather approaches that enable an analysis of what are generally viewed as taken for granted 'facts' and the examination of the ways the social organization of society can intersect to shape individuals' experiences.

The era of health reform between 1980 and 1997 in Britain was characterized by a considerable reduction in state-funded services and an expansion of services provided within the private sector. In this era constraint in public spending resulted in considerable reduction in services and as Hsiao (1992) observed in this period "the UK may have over-restricted its supply" (p.624). For the purposes of this research however it is important to note that the impact of such cuts was not evenly felt. That is, evaluation after decades of economic reform reveal the gap between rich and poor increased significantly and health profiles of the poor continued to deteriorate (Gordon et al, 1999; Marmot, et al., 1997; Wilkinson, 1996).

This discussion of the health policy context in Britain illustrates ways the social context and research and practice issues are manifest in the policy discourse. The production of evidence and the processes of assigning meaning to it is not linear. It is therefore appropriate to undertake work that introduces alternative perspectives into this process.

A New Policy Era in Britain: Matching Needs with Services

The late 1990s heralded a change in government with a mandate to focus efforts on health, education and social services. The Labour government, when newly elected, set a course that placed an emphasis on "matching individual needs with services" and a commitment to addressing health inequalities. "The NHS Plan: A Plan for Investment- A Plan for Reform" is described by Health Secretary Alan Milburn as the most fundamental and far-reaching programme of reform in the history of the NHS (Britain, DoH, 2000b).

The major areas of reform in this NHS Plan include: investment in NHS facilities including extra beds and new hospital schemes between 2000 and 2010; considerable investment in NHS staff; changed systems for the NHS and a National Independent Panel to advise on major hospital changes; changes between health and social services including investment in intermediate care by 2003/4, and New Care Trusts, combining health and social services; changes for NHS staff including new roles and responsibilities for nurses and new senior sisters; changes for patients including greater choice and new protection; changes in the relationship between the NHS and the private sector; cutting waiting times for treatment; improving health and reducing inequality including every child in nursery, and those aged four to six in infant schools to receive a free piece of fruit each school day and an allocation of increased resources to deprived areas (Britain, DoH, 2000).

The initiatives focused primarily upon improving facilities and modes of service delivery through re-organization of service delivery and the development of standards of care in specialty areas throughout Britain. The goals include improving health and reducing inequality.

Accompanying reform in Britain were considerable changes in organization and administration of health care services which are ongoing. It is however organizations at the frontline which "are responsible for translating national objectives into local policies and for working with other agencies to address the conditions which give rise to illhealth" (Spurgeon, 1998, p. 6). In keeping with this in recent years the government has sought to develop mechanisms for determining health needs of different population groups in order to meet its goal of matching services with needs. The appraisal of need has therefore been the focus of a number of scholars' research (Billings & Cowley, 1995; Cowley, Bergen, Young, & Kavanagh, 2000a,b; Silvera & Kaposi, 2000).

As Benzeval (1999) notes:

> "at the local level, it has been argued that the NHS needs to develop policies in three main areas to play its part in tackling health inequalities, by:
>
> • ensuring resources are distributed in relation to need
>
> • responding appropriately to the health care needs of different social groups
>
> • taking the lead in encouraging a wider and more strategic approach to healthy public policies" (p. 29).

In this body of work "health need" is viewed as extending beyond biomedical definitions to include social and economic conditions that interfere with one's ability to secure health. More recent government initiatives have set out to tackle inequalities in health more directly. These include initiatives to ensure all communities have access to screening, diagnostic and tertiary treatment but also initiatives at the community level to ensure health resources are located in areas of greatest need (Britain, DoH, 1999, 2000, 2002). And, while concerns about the costs of health care have persisted initiatives have been undertaken to redress identified inequities. That the government has recognized that social, material, community and health conditions intersect to create health needs is evident at several levels. An example at the broadest level is in the creation of the Social Exclusion Unit. While at the community level a decision was made to pilot an innovative initiative. Having identified a number of geographic areas of higher need, in which health inequalities are most evident, these were identified as 'Health Action Zones'. Health and community services within these zones were then in a position to benefit from a "range of innovative initiatives in housing, employment, education, access to healthy lifestyles, transport, neighbourhood

regeneration, community empowerment and health and social care" (Benzeval, 1999, p. 29). As well, ethnic communities were slated to receive particular attention in health resource allocation in an effort to reduce health inequalities.

Health and the Policy Agenda – Canada

Both Britain and Canada have a parliamentary system with Canada's system being modeled on that of Britain. The legislative process in Canada must comply with the Charter of Rights and Freedoms that defines the rights of citizenship and explicates the domains of responsibility allocated to different levels of government.

Each of the ten Canadian provinces and two territories has a system of government that parallels that of Canada's federal government. Provincial governments however, may have been elected with different mandates, philosophies and political agendas than those of their federal counterparts. As such, federal-provincial relations and their navigation, can be seen as a point of difference between the Canadian political and policy context and that of Britain. This relationship influences how health services and other provincially mandated programmes are delivered.

The federal government relies upon the co-operation of provincial governments to implement health care services.

> "The story of Canadian federalism is one of constant intergovernmental exchange and co-operation… For instance, the federal government...has used grants-in-aid to enter resolutely into the areas of technical and university education. Indeed the federal 'spending power' or so-called 'power of the purse' is at present being construed as a federal right to decide...whether provincial governments are properly exercising any and every right they hold under the constitution" (Trudeau, 1968, p.137).

While the example above refers to education similar negotiations are undertaken with respect to health. Monies for health are allocated to the provinces by the federal government as federal transfer payments for health (as long as the principles of the Canada Health Act are maintained). These funds are then supplemented by the provinces.

In the Canadian context therefore it is necessary to examine legislative and policy initiatives at both the federal and provincial levels. Further, in fulfilling its commitment to a universal system of health care, tensions between the interests of a central government and the provincial governments must be negotiated.

It has been argued that the ideology of community (versus individualism) informed many policy decisions at the inception of Canada's system of medicare. The roots of the national system are traced to programmes initiated in the prairie provinces, by the Co-operative Commonwealth Federation (CCF) who were in power in Saskatchewan's provincial government years earlier. In this region where people lived in small and isolated farming communities, faced severe winters and relied upon one another to help at peak periods of harvest, collective action was a familiar concept. "The settlers of the 'last best west' - became used to helping each other through collective and co-operative action" (Badgeley & Wolfe, 1967, p.3). This commitment to communities sharing the costs of illhealth was reiterated in the Royal Commission on Health Services Report of 1964 (Canada, 1964) which served as a precursor to the Canada Health Act (Canada, 1984). In this report the concepts of universality, accessibility and equity were identified as key components of a national system of health care.

The British example was drawn upon in the design of the Canadian system. Even in the early years, the link between poverty and health and access to health care was being made by analysts as the relationship between health and poverty had been documented in the UK. It was observed that in the British context "health and welfare programmes, supposedly of equal benefit to all, are not eradicating persistent social inequalities (Badgeley & Wolfe, 1967, p. 152). Therefore it was argued that in designing its own system Canada must attempt to ensure that "the ideals of social justice become identified with programmes to improve the economic lot of this submerged segment of our population" (Badgeley & Wolfe, 1967, p. 153).

From its outset Canada's national health system was based upon the premise that a healthy society is a necessity for a healthy economy and was designed to ensure that the burden of illhealth was shared, thereby diminishing the impact of the cumulative burden associated with illhealth on individuals (Badgeley & Wolfe, 1967). The first steps towards a national plan were taken when hospital insurance was introduced. This was followed by a comprehensive national health plan commonly referred to as medicare. As well as seeking to provide illness care the Canadian system also includes health promotion (originally public health) programmes as a component of its mandate.

The 1960s then, ushered in the era of a universal system of health care provision. Policy initiatives undertaken in subsequent decades influenced the ways in which services were delivered.

In the 1970s the policy titled: "A New Perspective on the Health of Canadians" widely known as the Lalonde Report (1974) shifted public health into an era of lifestyle interventions assigning individuals greater responsibility for maintaining health. In this same era different provinces began to examine ways of co-ordinating the different approaches to the delivery of health and illness care. One of the most influential studies was undertaken in Quebec by the Castonguay Commission (Castonguay, 1972)

Recommendations of this Commission were adopted and resulted in the development, in Quebec, of a system integrating three different levels of health and social services. The implementation of this decentralised plan was designed to enhance accessibility, recognize different communities might have different needs and include mechanisms for fostering community input into the ways in which local health and social service programmes and resources were developed and delivered. A similar model of community health centres was introduced in Ontario in this era. Such organizational reforms integrating health promotion and primary care in local centres with community governance structures would appear later in other provinces (see for example BC, 1992).

In addition to the community health centre model all provinces continue to have physician run family practice and specialty offices whose services are billed to the provincial medical services plan (medicare). This system differs from that in Britian in that in Canada if physicians choose to charge patients for insured services, they must completely opt out of the medical services plan. As in Britain, referrals from a family physician are required in order to be seen by a specialist (consultant) but unlike Britain, G.P.'s practices are financed by a fee for service billed to the medical services plan, and their patient group can draw from any geographic area.

In Canada, the major policy initiatives and government commissioned inquiries in the 1980s included the introduction of National Health Promotion and Mental Health strategies. The "Health for All" (Canada, 1986) policy extended the lifestyles approach to health promotion, recognized the role of community and relationships as creating a context for health and placed an emphasis on self care and social connectedness in health and illness management. This policy was subsequently drawn upon in the development of the WHO's health promotion strategy (WHO, 1986). The concepts of partnership and participation enacted within a supportive environment have since been articulated as central concepts in health policy, have been drawn upon to guide the policy development process and have provided direction to the ways in which decisions regarding the design of programmes and

resources are made. The subsequent national and provincial inquiries and Royal Commissions into health were designed to include consultation with, and presentations by, stakeholders. These included community groups, individuals, patients, service providers and professional organizations.

The 1980s continued to be a time of substantial immigration to Canada. The changing demographic profile prompted the federal government to establish a Task Force on Mental Health of Immigrants and Refugees. Their report published in 1988 drew attention to the unique health challenges faced by new immigrants and refugees. This report and the Mental Health policy (Canada, 1988b) developed in the same year made recommendations regarding ways of upholding principles of equity, accessibility and universality for immigrant and refugee populations.

Era of Reform

The 1990s marked a transition in government priorities. Canada, like other countries, entered a period of economic retrenchment. The shift in emphasis from spending to reducing debt prompted a review of government financial commitments. Expenses related to health care at both the provincial and federal levels are major components of the government budget (Canada, 200l- Mar). In this era the continued commitment to collective versus individual responsibility for health was called into question.

The process of review and reorganization associated with the process of reform began at the provincial level and was prompted in part by a reduction in federal transfer payments. In British Columbia the government established the Royal Commission on Health Care and Costs and assigned it a mandate to gather data and make recommendations to guide reform initiatives. The Royal Commission Report was drawn upon in the development of the province's current health policy "New Directions" (BC, 1992).

During this time of review each province explored alternative models of funding and service delivery and considered the merits of continuing with, or opting out of, the national system. As such the discussions and consultations included an exploration of the merits and challenges of continuing with a universal system, and reconsidering the viability of a two tiered system (i.e. privately funded with and without insurance schemes coupled with publicly funded services).

Focus on Underrepresented Groups: A Recommitment to Equity

In the same decade the federal government commissioned its 'National Forum on Health' in an effort to identify from the viewpoint of professionals, health care organizations and citizen groups the central elements of the system that were most valued and areas where costs could be trimmed. An additional mandate for this commission was to assess the currency of the founding principles of medicare. Their report affirmed that medicare is deemed essential by Canadians (Canada, 1997a,b). Indeed it concluded that Canada's system of medicare is a defining feature of Canada.

This report, like many of the provincial studies being undertaken, documented that certain groups, including, most particularly FN people but also, new immigrants, women, children and youth and the elderly were not receiving the same consideration in services as other sectors of the population. As a consequence these groups had poorer access to health services and poorer health profiles.

The report also noted that although Canadians recognized the value of health promotion initiatives, these were more highly valued by professionals. The report reaffirmed a commitment to a view of health that was broader than illness care and one that recognized the social determinants of health.

> "Although there are links between illness and health at an individual level, society's method for mobilizing resources to prevent and treat illness in the individual – the health care system– is not well suited to promoting health in the population as a whole.... More recently, in large part because of research on the non-medical determinants of health and on health promotion, the focus has shifted to the societal level, beyond factors that are within the immediate control of individuals, professionals, and communities.
>
> We believe that the social and economic determinants of health merit particular attention. This is not to diminish in any way the important contribution made by...(the system of illness care). Rather, our goal is to raise awareness of the far reaching implications of the social and economic factors and to propose concrete actions to improve the health prospects of Canadians" (Canada, 1997a, p. 1).

Thus, the National Forum, reaffirmed that the remit of Canada's health system extended beyond illness care. It identified groups requiring particular attention in research and programme development and proposed strategies to foster broader

based participation in the design and delivery of health care services while maintaining a commitment to equity, universality and accessibility.

Strategies for expanding resources while containing or reducing costs, as observed in the National Forum Report, included outlining a greater role for voluntary organizations and communities in working with the formal system. Increasingly, community based organizations to have input into the ways in which services are being developed.

The participation of women and others historically underrepresented in decision making bodies has been noted as an issue of concern in a number of other studies, both for women's health and for the ways in which services are developed and delivered. For example, in his report on the Health of Women in British Columbia in 1995, the Chief Medical Officer noted: "Although women perform much of the frontline work, they are not always in a position to influence the decisions which may affect their lives. For example, women have traditionally been underrepresented in public life and other positions of influence" (BC, 1996, p. 89). As a consequence efforts were undertaken, with some success, to ensure women were represented in community health Boards and other advisory bodies. Women have achieved equal representation with men as members of Regional Health Boards, Community Health Councils, and School Boards; approximately 50% of members are women" (BC, 1996, p. 89).

Interestingly, while the National Forum document may have drawn attention to overlooked groups and identified a role for communities and organizational partnerships, it did not lead to a new policy at the federal level. Similarly, while the Report affirmed the tenets of the Canadian system, affirmed the principles expressed in earlier health policy (Canada, 1986), and identified the need to take into account the social determinants of health, the federal government continued to enact its strategy of fiscal reform (Canada, 2001 - March). In the past decade the federal government in Canada substantially decreased the federal transfer payments for health to the provinces. This resulted in considerable reductions in provincial and territorial revenues for health. These reductions resulted in a re-examination of modes of health care delivery and a re-organisation of services in the provinces in an effort to enhance efficiencies.

Although not articulated in health policy documents, the economic policy decisions to reduce health care spending by the federal government implied a reduced commitment to health care as a federal responsibility. These actions prompt

us to consider whether provinces would be able to adequately address (allocate resources to addressing) the social determinants of health while they are simultaneously engaged in reducing costs of delivering illness services. To do so, while maintaining comparable levels of care, would require substantial re-organization, careful consideration in the re-allocation of funds within existing and new services, considerable creativity in designing initiatives, and one would assume a continued allocation of funds to research to guide the delivery of care.

The consequences of these decisions were keenly felt by the federal government. As provinces attempted to re-organize health services in an effort to fulfill service delivery commitments with reduced budgets they, and the population in general, continued to lobby for more federal funds. Each federal political party recognized that health care and commitments to it were priority concerns for the voting public. In the fall of 2002 the federal government commissioned a new inquiry into health care. This report, generally referred to as the Romanow Report (Canada, 2002a,b) made recommendations for preserving and strengthening the national system and perhaps most importantly, recommended that new funds be allocated. The latter recommendation was acted upon within weeks of the Report's release showing hope for the government's commitment to the health agenda.

Key Issues of the Health Policy Climate

An increased emphasis on economic efficiencies provided much of the impetus for health care reform in Canada and countries throughout the world. A number of analysts have argued that the emergence of the promotion of self-care and increased emphasis upon individuals assuming responsibility for their health and the exploration of cost sharing initiatives through the establishment of partnerships are markers that suggest movement away from a collective responsibility for health which may ultimately magnify the disadvantage some groups face (BC, 1998; Evans et al, 1994).

This concern about cost has meant that when groups are identified as requiring different approaches to care any initiatives must be justified on a basis of cost (and evidence). Also, in the insurance risk assessment model, some population groups are portrayed as commanding 'more than their share' of resources. This era then, has seen a shift towards discourses emphasizing efficiency and a re-emergence of health discourse that characterizes health as a reward for pursuing a healthy (morally good) lifestyle. Along with this there was pressure from a number of

groups to consider the implementation of a 'two tier' system of public and private health care with and without (private or public) insurance as is in place in a number of other countries. Those arguing against this model cite the considerable body of research which has documented such systems tend to provide different levels of care to different population groups and be associated with markedly different health outcomes (Abel-Smith, 1994; Evans, 1992; Feinstein, 1993; Hsiao, 1992; Frank & Mustard, 1994; Reinhardt, 1992; Stroik & Jenson, 1999).

Although the history of the health systems in both Canada and Britain has been premised upon similar commitments to universal care for their citizens, there are charges that as the countries have developed and the make up of their populations has changed some segments of the population have not derived equal benefit. Both countries identified the need to keep a healthy workforce in order to continue to develop economically and espoused a commitment to sharing the costs of illhealth among the broader population. There are a number of examples of the ways in which this commitment to collective responsibility has been eroded at different points in time.

There are however a number of conceptual issues and associated assumptions that underlie the ways in which issues faced by different population groups have been taken up in policy. While universality aims to ensure cost is not a barrier to access health services research cited so far in this chapter has shown that material circumstances, social position and the capacity to mobilize such societal resources have important influences on health status. Further, as has been noted some groups, notably women and particularly women heading families and new immigrants, have access to fewer such resources. As such, the health policy discourse includes an exploration of tensions between policies driven by efficiency and policies driven by equity.

Several authors have also illustrated the ways in which assumptions about women, and men, are taken up and acted upon in policy. So too, the ways in which issues of culture, race and ethnicity have been conceptualized, or overlooked, have had an impact upon how policy has been framed. In the next section therefore I examine the ways in which the discourse on culture has developed and been taken up in research.

Approaches to Understanding Culture & Migration

With the recognition that there are cultural influences on health and health practices the conceptualization of culture and cultural traditions has been central to the work of a

number of theorists. Nurse researchers have drawn upon a number of theoretical traditions in anthropology, sociology, philosophy and feminist theory in framing their studies. Work grounded in each perspective has contributed in different ways to the discourse on culture and health. Each perspective calls for different research approaches and each is built upon different, sometimes competing, assumptions. Work derived from these viewpoints has, therefore, contributed to an ongoing debate about the nature of culture and its impact upon health.

As noted earlier in this thesis, a number of theorists have sought to make visible the ways in which cultural viewpoints shape and influence how health is defined (Helman, 2000; Eisenberg & Kleinman, 1980; Good & Good, 1980). Culture and associated systems of meaning also suggest the nature of roles different people in families or communities play in assuming responsibility for ensuring the health of family members or managing illness events (Helman, 2000).

There is however an abundance of research that, in an effort to describe cultural beliefs and health practices, is problematic when it assigns people to categories based primarily upon ethnicity and contributes to the assumption that cultural communities, or ethnocultural groups or persons of the same ethnic background have the same beliefs and practices. Many of these authors do not distinguish between culture and ethnicity and simply document associations between ethnicity and health status, rather than focusing attention on the ways in which such associations are produced.

Limitations of the culturalist viewpoint as a perspective to inform social policy and practice are noted by Williams (1996).

> "The characterisation of individuals, families or communities being to blame for their deprivation because of their way of life, their culture, has long been part of common-sense ideas in... health care. But deeply embedded notions of cultural and racial superiority...gave rise ... to specific and often contradictory ideas of the deficiencies of Afro-Caribbean and Asian families and cultures... The problems of adolescents are translated in terms of their parents' maladaptive childcare practices (Williams, 1996, p. 68).

Examination of the assumptions underlying such conceptions of culture in research has been undertaken by a number of critical theorists. Ng (1988) for example challenges the assumptions inherent in labeling and argues that processes of labeling certain groups have

contributed to the production of negative stereotypical images. Further she argues that some of the labels assigned to immigrants have become a metaphor for an underclass in society. The examples she draws upon relate to 'women of colour' and an associated process of labeling women as 'immigrant women'. Such labeling, she argues, allows people to make assumptions about women's abilities and to categorize them on the basis of their visible features.

bhabha (1994) speaks of the need to challenge or shed labels and the social positions assigned by colonizers as a strategy for challenging the systems that perpetuate or lend credence to labels and associated social structures. Social systems of concern to bhabha include the language and social structures that define and shape intergroup relations. He argues for example that colonial discourse is an apparatus of power that "turns on the recognition and disavowal of racial/cultural/historical differences. Its predominant strategic function is the creation of space of a 'subject people' " (1994, p.70). A central concern in bhabha's work is to provide insight into the consequences of migration and the losses, particularly the loss of recognition, associated with migration. He writes of people with "unhomely lives" and stresses the importance of capturing and creating a sense of place. The effects of being 'without place' are pervasive and as he writes:

> ...inherent in that rite of extra-territorial and cross-cultural initiation. The recesses of the domestic space become sites for history's most intricate invasions. In that displacement, the borders between home and world become confused; and, uncannily, the private and the public become part of each other, forcing upon us a vision that is as divided as it is disorienting" (bhabha, 1994, p. 9).

The home-family context, in bhabha's view, is not separate from the broader social context within which it is situated. It can be viewed rather, as a site where cultural meanings, values and perspectives are both contested and renegotiated (bhabha, 1994, pg. 2). While bhabha, in eloquent terms, describes the disruption that accompanies migration and the personal and social challenges of negotiating a new place he also speaks to the creative possibilities offered by migration. Migration then, is conceptualized as characterized by change, uncertainty and loss of place, but also as providing an opportunity for newness, revision and possibility. He articulates the transformation that can ensue change, the rearticulation of roles and relationships that can become possible and in so doing effectively challenges a view of culture that views 'tradition', formality and social rules as immutable.

While bhabha helps us to understand the experiences of immigration and the layers of change associated with negotiating a new place and sense of self associated with it he does not specifically take up the structural or institutional influences on such experiences.

In writing about the place of refugees in their new countries, particularly in South America, Freire (1998,1970) explores the challenges of addressing the individual's desire to retain connection with his or her personal and social history and the need to locate oneself in the new society. Freire problematises the issue of cultural pluralism.

> "Cultural pluralism does not consist of a simple juxtaposition of cultures, and still less is it the prepotent might of one culture over another. Cultural pluralism consists in the *realization* of freedom, in the *guaranteed* right of each culture to move in mutual respect, each one freely running the risk of being different, fearless of being different, each culture being 'for itself'" (Freire, 1998, p. 156).

As such, it is Freire's (1998) position that there are obligations on the part of the newcomer and society to work to create the conditions of cultural pluralism. Such conditions he suggests develop in response to 'tensions'. Freire goes on to talk about the tensions (and here I think he uses the term tension as a force to prompt growth) that are a part of developing, emerging, changing, or dynamic cultures, changing not in response to fear (as is experienced in repressive regimes) but by self concern.

> "We must also realize that the society to whose space other ethnic groups, ... have come, to be 'absorbed' here in a subordinate relationship, has its dominant class, its class culture, its language, its syntax..." (Freire, 1998, p. 157).

Freire, like bhabha, offers insight into the nature of the interface between newcomers and the societies they join. Each speaks to the inevitability of change and seeks to direct such change in ways of mutual benefit. Freire however notes that mutual benefit will not occur 'by accident'. Rather, he notes there must be a commitment at the social and political level that is lived at the level of the community.

These observations locate cultural viewpoints as constructed by individuals but influenced by others and sustained by institutional processes. This view aligns with the perspective taken in this study.

As introduced in Chapter One Bourdieu also addresses questions related to culture and migration. Central concepts in his work include *habitus* and social capital. Bourdieu's (1990a) concept of *habitus* provides a lens for making sense of the everyday. It is, in effect, a lens through which individuals' expectations for interactions are formed and analysed.

While *habitus* offers a means for explaining and guiding day to day interactions, in a new social context one's *habitus* may not be useful as the assumptions made - about what is expected, what is viewed as appropriate for oneself or those with whom an individual is interacting. - in one context may not apply in the new context. But acquiring new ways of interacting Bourdieu notes is not simply an educational endeavour, it is rather, a negotiated act. In Bourdieu's view "competence ... far from being a simple technical capacity acquired in certain conditions, is a power tacitly conferred on those who have power over the economy or (as the very ambiguity of the word 'competence' indicates) an attribute of status" (1990, p.64).

To be viewed as competent therefore one must manifest behaviour that fits (or is seen to fit) within the defined social structures and processes. Competence then is culturally and socially determined and one's social location is both assigned and assumed.

> "A given agent's practical relation to the future, which governs his present practice, is defined in the relationship between, on the one hand, his *habitus* ...and on the other hand a certain state of the chances objectively offered to him by the social world. The relation to what is possible is a relation to power; and the sense of the probable future is constituted in the prolonged relationship with a world structured according to the categories of the possible (for us) and the impossible (for us)(Bourdieu, l990a, p. 64).

Thus the negotiation of social interactions provides opportunity for demonstrating competency and being recognized as having value, or the converse. Bourdieu's conceptual work links individuals' experiences with social structures and the power relations that underlie the ideological premises of social organizations (Bourdieu, 1990a; Bourdieu et. al., 1999). In his view *habitus* plays a role in supporting existing social structures.

Bourdieu (1990a) also draws attention to conditions that can shape and define social interactions and define the ways intergroup relationships will be structured. Therefore, if we consider concepts central to Bourdieu's perspective they provide ways of making sense of individual's viewpoints in relation to broader institutional processes.

Bourdieu (1990a) discusses traditions, as taken for granted practices characteristic of societies. Traditions provide a way to structure interactions and provide guidelines for constituting relationships between persons with different roles, and guidelines for making sense of institutionalized expressions of power and authority. Traditions can also however assign some people authority or power while usurping that of others. Drawing upon Bourdieu's contention it could be argued that traditions are meant to be perceived as benign and engaged in without questioning. As such traditions, while creating the 'familiar', also

have the potential to structure power relations to serve one group's interests over another.

Bourdieu's conceptual work recognizes the role of power in sustaining institutional processes. A number of other theorists have identified that oppression is central to the experience of cultural groups. Work in this area has been strongly influenced by feminist theory which has sought to make visible the ideologies and structures that have historically privileged men on the basis of gender. A central premise of feminist analysis is that the processes of assigning and exerting power are based on gender and that the social context in which we live is structured to privilege groups on the basis of gender. A consequence of this is that women are more vulnerable to oppression.

Examinations of power and oppression have entered the health discourse via other routes. A principal theorist is Foucault whose analysis called attention to the nature of power and who distinguished between relational power and disciplinary power (see for example, Gordon[4], 1980). Exemplars of the latter were provided by Foucault's analysis of the 'clinic' in which he argued professional disciplines conceptualized their role as assigning them particular powers. In enacting their relationship with their patients, professionals were conferred the ability to define and treat illness in ways that incorporate surveillance, assign power over another, create structures (space, policies, procedures) to reinforce the professional's power or position.

Disciplinary power is distinguished from Foucault's conceptualization of relational power which assigns power to each person. Other conceptualizations of power have not made this distinction and so have appraised power as residing within, or being held by, others. The distinction is an important one, for it assigns a role to each participant in interaction. While Foucault's analyses have enabled us to revisit assumptions about the social organization of health care and the 'rules' governing relationships between professionals and patients his work is criticised because it does not offer a way forward by suggesting alternatives to situations deemed problematic.

Bourdieu's work also has as one focus the examination of intergroup relations, particularly the relations of colonizer to colonized. His analyses seek to explicate the ways in which social structures shape and in some instances constrain the ways interpersonal relationships are constituted. His conceptualization allows one to focus on questions related to interrelationships at multiple levels including; social structures and organizations, community, family and individual.

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[4] Gordon is the official translator for this piece of Foucault's work.

A second concept central to Bourdieu's theoretical perspective is social capital. Bourdieu recognizes, and draws a distinction between, different forms of capital (Bourdieu, 1986). In his view people draw upon different forms of capital such as: economic, cultural and social. In exploring these forms of capital Bourdieu illustrates the ways in which society sanctions or accords privilege to groups with different forms of capital. In so doing he also makes visible the ways in which some groups can be socially excluded or marginalized in part because their capital is not recognized or because in a particular context their capital is not a 'currency' of value. Much of Bourdieu's work has used the educational system as a case for illustrating these social processes.

Social capital represents the value or recognition accorded a person as a result of his or her participation in, or contribution to, the functioning of the social group. While Bourdieu identifies multiple forms of capital, social capital is likely to be the concept of greatest interest in this research. Bourdieu has conceptualized social capital as context dependent. That is, its value is socially determined and assigned based upon the social context within which it is contributed or drawn upon. Social capital is of interest in this research as the concern is to focus on the work undertaken within and by the informal network. I argue in part that such work is largely invisible yet essential to the health care enterprise. Such capital or resources however are not independent of the existence of other types of capital. Following from Bourdieu it can be argued the value of social capital can be augmented when one also holds cultural or economic capital for such forms of capital allow one access to different social forums.

Bourdieu also contends that power exerts an important influence on the social processes that define and institutionalize the relative value of cultural capital. He draws upon his research in the educational system in France to illustrate the ways in which education and credentialling processes inherent in the educational system legitimize and institutionalize some forms of knowledge (and social capital) as holding greater value than other forms. One argument Bourdieu makes is that such decisions are made by persons with the greatest amounts of capital thereby effectively excluding those with different forms of capital from participating in, or being recognized by, such systems.

Bourdieu's concepts are seen to be particularly useful because they do not rely upon 'static' definitions but also because they recognize the dynamic nature of social interactions and the meanings assigned to them.

Hodgkinson (1998) drew upon Bourdieu's perspective in examining the ways youth undertook career decision making. In presenting his analysis he demonstrates the contextual

nature of both *habitus* and social capital. That is, to be useful and of value, their value must be acknowledged by the 'other'.

> "As players in the field they had capital, which they used to try to achieve the ends they desired, remembering as has been already explained, that their actions in using their capital, and the availability of capital itself, were themselves both constrained and enabled by their habitus and their individual horizons for action. .." (Hodgkinson, 1998, p. 98).

Although this example does not deal with health it does provide an illustration of the ways Bourdieu's perspective (and the concepts of it) can enable us to take a second look at, and consider alternative explanations for, observed patterns of action. In this case career choice. His perspective illustrates how, although individuals ultimately make a choice, options are socially determined, through processes that limited these youth's access to possibilities and processes that assigned value to the capital available to them to draw upon.

Summary

The literature reviewed in this chapter provides an overview of historical trends in health policy in Britain and Canada and identifies key issues of the current policy contexts. Theoretical issues related to the ways in which culture and health are conceptualized and taken up in policy were explored and key works related to health inequalities examined.

The intersectionality of culture, gender and disadvantage and the challenges of explicating the ways their influence is manifest in health has been taken up in recent years by a number of theorists. The evidence to refute the view that health inequalities can be explained by groups' beliefs and values continues to mount.

Emerging perspectives have sought to consider the social effects of disadvantage. Broader perspectives on health have been introduced into health policy discourse. These draw attention to the nature of community and relationships within community for those facing disadvantage. These concepts show promise as explanations for differential health status within population groups.

The literature reviewed here illustrates the need for inquiry that attends to the ways realities, or formal representations, are socially constructed and in particular illustrates how representations can privilege some groups over others. Research informed by such a perspective has, in other contexts, been used to further discourse by offering new interpretations or presenting alternative views. The

methodological perspective taken in this study, which offers this possibility, will be described in the chapter that follows.

Chapter 3

Methodological Orientation, Study Design, Methods of Data Gathering & Analysis

In their exploration of qualitative research paradigms Guba and Lincoln (1994) argue that theorists must make explicit the ontological, epistemological and methodological tenets of their method of inquiry. This chapter introduces the methodological perspective that guided my movement through the different phases of the research and locates this perspective in relation to the methodological tenets of critical interpretive analysis. These are followed by a description of the study design and methods employed in both levels of data gathering and analysis.

Methodological Issues and the Criteria of Adequacy in Critical Analysis

Pierre Bourdieu and Dorothy Smith provide theoretical and methodological tools for linking individual experiences to broader social processes that are extralocal but that shape the ways in which experience is structured. Both Smith (1987a,b) and Bourdieu and colleagues (1999) direct this broader examination towards a critique of the ideologies and discourses that guide the development of policy and practice. Such ideologies and discourses are historically grounded.

Critical theory is premised upon the view that realities are socially constructed and sustained. One purpose in undertaking a critical analysis is to examine the often taken for granted assumptions that underpin a particular social process or phenomenon in order to consider the adequacy of the assumptions to the case of interest.

The methodology for this research is premised upon several assumptions. One is that social structures and processes both influence and shape individuals' experiences. Social structures in turn are reflections of an ideological stance or perspective informing policy. Therefore several types of data explicating different perspectives are gathered and submitted to analysis.

The data sets to be drawn upon, as will be described in greater detail later in this chapter, include interviews with mothers and daughters, data regarding programmes and resources and official policy documents. First however, I introduce the premises of critical inquiry and how they were taken up in this study.

Premises of Critical Theory

In conceptualizing the methodological perspective that informs the design of this research I draw upon the work of a number of theorists most notably bhabha, Bourdieu, Lather and Smith. Each adopts a critical stance and launches their inquiry from the perspective of groups in the 'margins'. Lather and Smith's work focuses on women while bhabha and Bourdieu focus on the colonized although some scholars have undertaken a gendered analysis while also taking direction from Bourdieu (Reay, 1998a,b). These theorists also direct their analyses towards the interface between institutional processes and individual experiences and each addresses different forms of power as well as recognizing, and seeking to make visible, different forms of expertise.

bhabha (1994) focuses our attention on the impact of migration, the points of difference and possibilities for transformation. His work names the family and relationships within the family and between the family and society as locations of intercultural boundaries. Like Bourdieu, bhabha views such interfaces, or boundaries as potential sites for, or points of, transformation. Bourdieu's perspective provides direction to an analysis of culture as a resource for managing the day to day, the processes of transforming culture and the capital drawn upon and generated through interactions. His conception of *habitus* accords value to tradition and experience but extends this to recognize that such personal knowledge must be transformed in new social contexts. Taking direction from these theorists, women and daughters were interviewed, individually and jointly, in their homes and in the community.

The view of culture as both a resource and a capacity that is dynamic is compatible with bhabha's (1994) characterization of the potential for cultural transformation that migration can prompt. Bourdieu's conceptualization of process of transformation (of knowledge) of *habitus* is an individual's response when new knowledge or competencies must be acquired in order to participate in a social process. Such transformation is most likely to occur when there is a disjuncture between the individual's own experiences and the new situations being faced. One point for examination is the impact or influence of this process of transformation on the person's sense of self. That is, does undertaking transformation lead people to feel empowered, or capable of dealing with new challenges? Or, conversely, does the need to change evoke feelings of inadequacy or a sense of having one's competencies or abilities overlooked? Or, does the situation and the process mitigate the latter while fostering the former?

Both Smith (1987a,b, 1990) and Lather's (1991) work, recognize different forms of expertise (types of knowledge and resources) and each has demonstrated the consequences for women of having their viewpoint eclipsed when the social institutions (i.e. health care

system, education, workplace etc.) are organized to reflect other (generally male) life experiences. Lather (1991) in particular writes about the research encounter as an opportunity for discovery, or the realization on women's part, that being 'eclipsed' is an experience many women share and a phenomenon that is produced by broader social organizational processes, and not the woman's 'fault'. She also writes about research as *praxis* illustrating ways research can create a context for the possibility of generating insight. In structuring my interactions with the women I was guided by these principles.

Critical theory charges researchers with an emancipatory mandate. That is, the goals of research must be motivated in part by an intention to generate knowledge that can make a contribution to an improvement in the health status or social conditions of the population of concern. More than this however, these theorists, in different ways, take the position that where possible the research participants themselves must in some way derive benefit. Lather for example, proposes that emancipatory research practices must avoid substituting one totalizing explanatory framework for another and argues instead that we must focus on becoming "less masters of truth and justice and more as creators of a space where those directly involved can act and speak on their own behalf" (Lather, 1991, p.137, emphasis added). Taking direction from Lather then, and in ways compatible with Bourdieu and Smith, women (mothers and daughters) were invited to speak about their experiences and issues related to migration and settlement in their new communities that were of central interest and concern to them.

Each of these theorists acknowledges that individual experiences are socially organized and bhabha, Smith and Lather in particular have explicitly considered ways in which power is manifest in institutional processes. Both Bourdieu (1990a,b, 1999) and Smith's (1986; 1990) methodologies provide direction for an analysis of the social structures and policies and the premises that inform them.

As such then, the chosen perspective should provide a mechanism for examining experiences in relation to broader social processes and in so doing create the possibility of making manifest the ways such experiences are socially organized. Research employing such a perspective therefore has the potential to contribute to dialogue on directions for social and institutional change. Key to these theorists' conceptualizations is the need to gather data from persons living the experience. Or, as Williams and Popay (1994) describe it, researchers must create a means for local voices to be heard in the policy process.

Methodological Premises of Engaging with 'local voices':

The Role of the Researcher

In undertaking research of this nature the researcher is actively engaged with the participants in understanding the challenges faced by the population of concern and the strategies employed to make sense of, and take action on, the situations they face. Bourdieu's (1990a) logic of practice asserts that "contrary to positivist materialism, the objects of knowledge are constructed, not passively recorded" (p. 52). Bourdieu's stance is one which offers an alternative to "reducing knowledge to mere recording" (p. 52) without "falling back into subjectivism, which is quite incapable of giving an account of the necessity of the social world" (p.52).

Bourdieu adopts the stance that the researcher is engaged in the creation of discourse, and as such it is necessary to identify the researcher's relationship to the focus of inquiry.

> "The status of an observer who withdraws from the situation to observe implies an epistemological, but also a social break, which most subtly governs scientific activity when it ceases to be seen as such, leading to an implicit theory of practices that is linked to forgetfulness of the social conditions of scientific activity" (1990a, p.33).

In effect Bourdieu problematises one of the premises Munhall and Oiler (1993) declare as underlying qualitative work.

> "Reality is constituted in a complex interaction of one's historicity, which includes the common stock of knowledge passed on through the culture in which one resides, and a chosen perspective on the world" (p. 427).

In undertaking this research I worked with people with different social histories from one another and from my own as researcher. Additionally, however, it cannot be assumed that we will share a 'common stock of knowledge' rather, a part of the conceptual challenge and the problem to be addressed is the possibility of gaining access to understandings, viewpoints and perspectives that are outside of what is largely taken for granted. Gaining access then is a central methodological issue for on it hinges the possibility of creating a perspective from which a critique of the formal, prevailing view, can be undertaken. The observer or researcher, rather than being a 'participant-observer' which in Bourdieu's view is a contradiction, takes the role of 'participant' and seeks a "critical awareness of the conditions of the production of theory" (1990a, p.36).

This role is consistent with Smith's (1990) concern to begin from the standpoint of women and draw upon data gathered from this perspective in order to undertake an analysis that examines the relationship between experience and the social structures that shape and influence them. Smith's work and work by others (Cotterill, 1992; Dyck, Lynam & Anderson, 1995; Edwards, 1990; Lynam & Young, 2000; Nast, 1994; Reay, 1996a,b) underscores the

importance of both the point of entry to the sites of inquiry, the nature of the relationship between the researcher and research participants and the need to create an opportunity for the participants to both define and explore topics or issues of relevance within the context of the research relationship.

This view is echoed in part in Heron and Reason's (1997) articulation of a paradigm for participatory inquiry. They note that:

> "inquiry methodology within a participative worldview needs to be one that draws on this extended epistemology in such a way that critical subjectivity is enhanced by critical intersubjectivity; a collaborative form of dialogue as coreseachers and as cosubjects" (Heron & Reason, 1997, p.283).

These authors go on to note that their perspective is motivated in part by a desire to stem the prevalence of "qualitative research *about* people" by conducting "cooperative research *with* people" (p.285). Their commitment finds expression in the articulation of partnership at all points of the study design, from problem identification, to study design and approaches to analysis. They specifically identify as problematic the issue of researchers 'speaking for' study participants and seek in their methodological perspective to undertake a joint construction, with a combatant to the creation of 'transformative' knowledge (Heron & Reason, 1997, p. 288).

An additional dimension of the 'researcher-researched' relationship when taking a feminist and post-colonial perspective is reflexivity. That is, central to the research process is active reflection on the part of the researcher on her influence on the ways data are being generated and interpreted. My interest in pursuing this research builds from my nursing work with immigrant women and teens. Although I am not an immigrant or a person of colour, I am committed to exploring ways to ensure health care professionals in general, and nurses in particular, develop an awareness of and develop the ability to access and act on knowledge of others' experiences. In most cases our work is relational and relies upon negotiating understandings with others. As persons holding formal power in health care organizations it is my view that we must seek to understand how our position influences our relationships with the people who are the targets of care delivery. The process of reflection in research of this nature attends most particularly to the ways in which power relations are manifest (Reay,1996a,b). How the study is presented, how the research agenda is pursued and how the research relationship is negotiated are therefore considered dimensions of the study design.

While such issues can be considered and planned for at the outset of the research, a number of authors argue that in research of this nature, the researcher must continually be

engaged in processes of reflection, about process, about content, about the nature of the research relations (Dyck et al, 1995; Lincoln, 1995; Nast, 1994) and be prepared to modify the study approaches as necessary. In commenting on a cross cultural study in health care settings Dyck and colleagues (1995) note that such reflection:

> "laid open to view the ways in which our positioning as researchers, backed by an institution embedded in the social relations of dominance and by concepts generated through academic practice, hold power in how knowledge about subordinate groups is constructed. If we recognize that women researchers are participating in the same social world as those being 'researched' we need to explore carefully how we are part of creating and contributing to the social reality of study participants. The methods we use are, therefore, not 'innocent', but are integral to how we can construct knowledge and represent the other" (p. 623).

Their work illustrates how such reflections and reflective processes in turn become a part of the 'data' and inform the analytic process.

Gathering Data: Sites and Perspectives

In recognition of the informal community and families as sites where cultural meanings are negotiated and *habitus* drawn upon, I began by eliciting the viewpoint of women in small groups in a cultural community context familiar to them. These group interviews were followed by interviews with the women and their daughters in the home context.

In keeping with the theoretical premise that experiences are shaped by the social and organizational contexts within which they occur, additional data from key informants in both formal and informal organizations were gathered. These data add additional information about and perspectives on the organizational and policy contexts shaping women's experiences.

Specific policy documents and related research and reports that shape or define the policy context for Britain and Canada were then reviewed and analysed as data. This format of interviewing and policy review was undertaken in each country.

Approaches to Conceptual Analysis

A first step in the analysis was to draw upon the data to examine the issues faced by first generation immigrant women and to explore the processes or approaches undertaken by women to deal with them. The preliminary analysis documented the personal resources (viewpoint, philosophy, knowledge, *habitus*) and interpersonal resources drawn upon in

making sense of, and managing, the day to day issues. Forms of capital that are drawn upon to manage day to day, developmental, family or health related events or issues were then described. Similarly, fields of relevance and issues related to gaining entry to new fields will be examined in the analysis.

Key concepts related to the processes of interest introduced above, were the points of interface between old and new, familiar and unfamiliar, formal and informal, family and community. Smith (1987a,b) refers to these as the 'line of fault'. Similarly bhabha characterises them as the points of interface. As such the data gathering process and the focus of analysis directs attention towards points of interface as these are likely to prompt reflections, make manifest disparities in *habitus* and identify the social and structural processes that in this case contributed to participants' experiences of marginalization and exclusion. How these concepts guided the analysis is discussed in greater detail as they are used in the analysis chapters to follow.

Both the use of, and contributions to, informal networks and interactions with persons, programmes or resources of the formal system will also be described. The goal of this analysis will be to explicate the participants' resources and produce a thick description or contextual representation (Bourdieu, 1990a) of the nature of the relationships that offer support and the types of knowledge and perspectives available as resources for the participants. This representation is to be distinguished from a structural description of relationships which Bourdieu (1990a) argues

> "tends to conceal the fact that the logical relations of kinship, which the structuralist tradition almost completely autonomizes with respect to economic determinants, exist in practice only through and for the official uses made of them by agents whose inclination is to keep them in working order" (1990a, p.35).

Bourdieu argues that it is more helpful to view such structures as providing a map "an abstract model of all possible routes" (1990a, p.34), that then allows or enables the subject to choose what route(s) might be taken.

The map of interest in this study is the map of relationships that the women participate in as a means of meeting family health needs. In effect, this is a map of the transactions related to social capital and how such relations are drawn upon and contributed to.

After the initial categories were developed and preliminary analysis undertaken participants' accounts were contrasted and compared to reveal conditions underlying and influencing experiences. For example, when participants spoke of exclusionary practices

these were compared with accounts of inclusionary practices or accounts in which exclusion was challenged. Additionally, the conditions (local policies or institutional practices) that contributed to these experiences were identified. Similarly, comparisons could be made between individual's experiences and conditions that fostered them within or across sites. Such comparisons allowed me to gain an indepth understanding of the participants' experiences of marginalization and the processes of exclusion.

In the subsequent steps of the analysis concepts and processes identified in the preliminary analysis were drawn upon in order to 'interrogate' the theoretical premises of policy and programme initiatives (Bourdieu et al, 1999; Harvey, 1990; Smith, 19887a,b; 1990). Policy documents become data for examination. In this step of the analytic process analysis of data gathered from 'local voices' is drawn upon to critique assumptions of policy and to identify disjunctures between stated policy aims and strategies. The discussion that ensued examined the ways in which ideologies find expression in policy and programme initiatives and critically appraises their implications for the population of concern.

A range of policy documents and literature analysing policy were sampled based upon the central concepts identified in the first stage of analysis. These are then examined in relation to individuals' experiences. It is at this point of analysis that possible ways forward can also be discussed. The procedures involved in this step of analysis follow.

How the Study was Undertaken: Defining the 'Field' of Inquiry

It has been argued that the site of entry can influence the ways in which the researcher: researched relationship is constituted in that the researcher can be viewed as aligned with the organization (if it is professionally driven) (Dyck et al, 1995) or be viewed as a 'guest' or possibly voyeur if it is community based (Nast, 1994; Edwards, 1990). Such alignments can become a source of influence and have the potential to magnify or minimize the power differential between the researcher and study participants. One strategy for sharing power with the participants is to use the participants' community as the site of entry. It was decided that study participants would be identified through contacts with community based organizations and that the first point of contact would be in a group setting with other study participants where the researcher was 'in the minority'. One rationale for this decision was that earlier work documented that ethnocultural organizations played an important role in providing women with support and information about the broader community (Lynam, 1985) and also because I am interested in the social organization of the informal community as a resource and point of entry to the formal system.

Sampling

This research employed a purposive sampling strategy. That is, the sample was selected for its ability to provide in-depth study of a phenomenon. People "enter qualitative studies primarily by virtue of having direct and personal knowledge of some event...that they are able and willing to communicate to others" (Sandelowski, 1995,p. 180). Sandelowski debates different sampling strategies within a purposive sampling approach. The key consideration in her view is that the sample be able to speak to the question of interest and that the participants have varied experiences with the phenomenon of interest. She refers to this as purposive sampling with *phenomenal* variation.

If resources allow, Sandelowski (1995) suggests that the sample can broadly vary to include representativeness of a number of demographic features, a strategy she terms *demographic* variation. Rather than including participants that reflect all demographic categories (i.e. gender, age, income, race) in one study she suggests that multiple studies with different demographic parameters be undertaken, the data from each study synthesized and then submitted for analysis.

In the case of this study, the central phenomenon of interest was the nature of first generation immigrant women and their daughters' relationships within the community. As such, women living in different social contexts but with similar histories of migration, were invited to participate. In determining the adequacy of the sample and the comparability across sites I considered a number of factors including family structure and education level but also I sought to include participants who recounted positive experiences (i.e. school success, employment success, experiences of affirmation) as well as those who recounted negative experiences (i.e. accounts of victimization and exclusion). Also, in undertaking the analysis I made decisions about additional interviews that needed to be undertaken in order to ensure I had adequate data to illustrate the processes I was describing. For example, in analysing ways women set out to mitigate exclusion I examined the data to assess whether there were sufficient examples to illustrate the types of conditions (i.e. women's perspectives, organizational processes) that made initiatives possible.

As will become evident in the analysis chapters to follow while my initial interest was in exploring how mothers and daughters drew upon their relationships or contributed to the creation of resources for managing health, as interviews were undertaken it became evident that although a number of families were dealing with health and illness issues (i.e. depression in a teenager, asthma, cancer, autism, arthritis, and concerns about teen sexuality) and some were experiencing difficulties accessing services for a number of reasons which included language issues and/or service availability, their prevailing concerns were

characterized by marginalization These participants did not however make ready links between their social circumstances and health.

Determining the Eligibility of Participants for the Study

As outlined earlier, an important dimension of research within this paradigm is that a study be designed to maximize the possibilities for the women, both mothers and daughters, to participate. Points of participation could include: defining the areas of concern, thereby shaping the ways in which the phenomenon of interest is viewed, leading the discussion and being given 'permission' to challenge, redirect or shape the ways in which the study is undertaken.

In constructing the study I am aware that in the field of interest I am an 'outsider' in that I am not a first generation immigrant woman, and am not a 'woman of colour'. As a professional, aligned with a University I am part of a community that many of the women, who were potential candidates for the research, have only visited as 'guests', as patients. As such, my position is likely to be seen as one of relative power. In making a commitment to a feminist agenda in research I sought to be attentive to the points at which the study participants might exercise their own power.

Women, who were also mothers of teens and had teenaged daughters, who were first generation immigrants from non-English speaking countries were the population of interest. As the literature and previous research suggests that visibility, language, gender and material circumstances influence the process of settlement I sought a sample that had to deal with these issues subsequent to migration. Also as the nature of family work changes as children move through different developmental stages I sought to include families with children. I chose teenage girls because teens as a group are viewed to be 'healthy' and it has been noted both immigrant teens (Canada, 1988a) and youth in general (BC, 1992, 1995; Canada, 1997a) have been overlooked in the health policy process. Also in Britain, as noted earlier, in the neighbourhoods I was focusing on, pregnancy in teens under sixteen years of age is a significant problem. This literature suggests that teens, particularly teenaged girls, merit some attention in health research.

Also the theory underpinning this study design focuses attention on points of interface as areas that prompt reflection and may draw attention to changing conditions and expectations thereby making taken for granted aspects of life more accessible. Therefore, interviewing both teens and their mothers allowed me to gain insight into the complexities of daily life and the ways in which these individuals interface with both formal and informal organizations within the community.

Data Gathering

It was decided that both *group* and *individual* interviews would be conducted. For each Case Family participating there was a possibility of three types of interview data: group interview, individual interviews with the women and individual interviews with the daughters. Additionally, after the study was underway a fourth type of interview data was also gathered for a number of the Case Families joint (mother and daughter) interviews were also conducted.

The *small group* interviews were the women's first point of contact with the researcher and it was proposed they be held in a meeting room in either the community agency that had helped with their recruitment or a local community meeting place like the community library. In the end, two groups in London and one in Vancouver were held in community organization meeting rooms, one Vancouver group was held at the university at the request of the participants and another Vancouver group was held in one of the group participant's homes. The small group interviews were followed by individual or joint interviews with the woman and interested daughters. These interviews were scheduled in the woman's home or another place convenient to her.

Several 'decision points' for the women were anticipated in the initial study design, and others became manifest as the study was undertaken. For example, in the initial design mothers of teenage daughters were invited to participate. Their daughters were also invited to participate, but were not required to do so. In the home interviews it was suggested that the interviews with the mother and daughter be conducted separately, but if the participants preferred, the interviews or portions of them, could also be jointly undertaken.

A protocol for data gathering in the small group context was developed for this study taking direction from an earlier study with small groups undertaken by the researcher and colleagues (Lynam, Gurm & Dhari, 2000). The protocol for this current study (see Appendix 1) outlined the procedures for structuring the group, laying the ground rules, and obtaining consent. Morgan (1988) outlines a number of factors to be considered in making a decision about the composition of groups. While all groups were with first generation women with adolescent daughters I decided to structure the groups on the basis of common ethnocultural background. That is, there were groups of participants formed on the basis of women's identification of themselves as Latin American, Vietnamese, Chinese Canadian etc.

These decisions were made for several reasons.

a) The immigrant serving organizations identified clients by their ethnocultural background or, in the case of one multicultural organization, provided programmes for groups of people on the basis of a 'common heritage'. As such the client group for the

voluntary organizations had already 'self-selected' themselves into groups by ethnocultural background.

b) Language has continually been identified as a key factor influencing peoples' experiences post migration. All participants in each group spoke the same first languages and had varying levels of English language skills.

c) A premise of my research has been that I will engage in a joint exploration of the women's experiences with them, and although the study design is not action research based, the methods are meant to, where possible, foster praxis. In two previous experiences with group data gathering (Lynam & Young, 1997; Lynam et al, 2000) participants commented that by participating with others in a discussion of common experiences new insights into their own experiences were gained, and for some, new community based connections were formed. While others have made similar observations through research using individual interviews it seemed there could be advantages to using both individual and group interviews.

d) It has been documented that when people are considering who is in a position to provide support, considerations include the premise that potentially supportive (understanding, helpful) others have had a common experience or by virtue of having managed an issue effectively in the past are seen to hold expert knowledge on the issue of concern (Lynam, 1985,1990,1992,1995). Therefore, it was decided that groups would be comprised of persons from a self defined community of common interest (i.e. ethnocultural parent organization for a particular geographic region) who shared some common experiences by being first generation immigrant women with adolescent daughters.

Small Group Interviews

As the groups were assembling, the researcher provided refreshments (fruit, cold drinks, baked goods) for the participants, people were welcomed as they arrived at which time the researcher introduced herself to each participant. Name tags were provided to facilitate the use of individual participants' names throughout the group interview. Several researchers have described these initial activities in an individual interview process as 'processes of social placement' (Dyck et al, 1995; Edwards, 1990). That is, in an individual interview context what initially were construed as 'social' conversations between the researcher and participant upon reflection were viewed as part of this process of social placement. In commenting upon how this process unfolded in one study Dyck and colleagues (1995) noted: "a number of social markers along various axes of similarity were

drawn on as the women placed each other" (p. 621) and negotiated the researcher-researched relationship.

In this current study in the group context a similar process was observed between the small group participants, particularly where the participants were not known to one another, and between the participants and researcher. Discussions between group participants focused on inquiries related to countries of origin, time in Britain or Canada, current neighbourhood, schools children attended and, for some, their involvement with the community based organization.

'Markers' of particular interest between myself and the women were our common roles as mothers of teenaged daughters, my role as a nurse, my work with other first generation immigrant women and families, and when I was in Britain, my time there. For some study participants in London, my ties to King's College, evident in the letterhead on the consent forms etc., were ones that were salient as some participants commented upon care received at King's College Hospital. While in Vancouver, my ties to the University of British Columbia were of particular interest to some study participants and resulted in requests for information about nursing and other programmes of study available there.

Ethical Considerations

Ethical approval to undertake the research as designed was obtained from the Ethical Review Committee of King's College London for the sites in Britain and the University of British Columbia Behavioural Science Ethical Review Committee for Research with Human Subjects, for sites in Canada.

Obtaining consent: Written consent was obtained from each of the women participating in the study. Although I wanted to conduct the interviews in English I anticipated that some of the women might have difficulty reading English. For this reason I read the Letter of Information and Consent (Appendix 2) out to the women prior to having them sign it. I also had these letters of information and consent translated into Chinese and Spanish for two of the groups as an additional precaution to ensure the women understood the purpose of the research, the nature of their involvement in the study, and the ways I would seek to ensure confidentiality.

Similar letters of information about the study had been provided to my agency liaison people so that they could use the information when inviting women to participate. As such, I found there were few questions from the women about their involvement in the study. The questions women did ask pertained more to the links between this research and other

work I had undertaken and questions about the similarities or differences between what I was observing in London to what I was observing in Vancouver. Also, questions sought to clarify the role of their daughters in the research and whether the individual interviews (with mothers and daughters) needed to be conducted at the same time.

As noted in the protocol for the small group, the interview questions were designed to tap into general knowledge as opposed to personal or private knowledge about the participants' experiences and relationship with resources within the community and their interface with the formal system. Information about participant's individual experiences was reserved for the individual interviews.

Honoraria: An honorarium was offered to the participants upon completion of the group and individual interviews. The mothers were offered £15.00 or $25.00 and daughters were offered £5.00 or $10.00. The decision to offer an honorarium was made in an effort to recognize the value of the women's time and their 'expert' knowledge. As I am recruiting women who are on the social and economic margins of their new communities I thought it important to offer an honorarium as an 'exchange' for their involvement and as a means of defraying costs associated with participating. Such costs might include for example, bus fare to the community setting for the group interview which in London could be £2.00 or £3.00 return.

Although in the nursing research literature there has been little or no discussion of honoraria it is widely practised - although not often commented upon in research reports - in research in biomedicine and psychology. Offering honoraria, has also been discussed as an issue with moral and ethical dimensions in the social science and feminist literature.

In their discussion of the issue of paying research subjects, Dickert and Grady (1999) observe that it is more commonly practised than is acknowledged. They suggest that offering payment has not been seen as an issue for healthy subjects and has only been raised as an ethical issue with respect to ill subjects. After considering a range of options they conclude "the wage-payment model represents the most ethical approach to paying research subjects, and we think it is an approach that can be successfully implemented" (p. 202). They argue that this model recognizes the time commitment of study participants.

Thompson (1998) arrives at a similar conclusion but argues that paying study participants is particularly important for those who are less powerful or facing greater disadvantage. Such persons she notes are more likely to be the subject of study and less likely to be in a position to object. As she observes "payments are rarely considered in designing qualitative research. This may be because the researched are often those lacking

the power to insist on being compensated for their time, as experts or consultants on their own values, knowledge, skills and experiences" (p. 2). Thompson argues that receiving payment offers a means of equalizing power imbalance, an issue a number of authors note to be of particular importance in the design of research.

One rationale for offering honoraria is as an incentive for disadvantaged groups to participate in research. It has been noted that many disadvantaged groups are under represented in research in part because methods of recruitment may not tap into the social networks of such participants, or because they cannot afford the time or manage the costs (travel, childcare etc.) associated with participating.

The Small Group Interview Process

As outlined in the small group protocol, after greeting individual participants and seating the group a first activity was to obtain written consent.

Written Consent: All participants had been given a description of the purpose of the study by the person from the agency who recruited them. After people were seated I distributed consent forms and letters of information to each participant. As outlined above these were read out loud to the participant by the investigator and opportunities to ask questions and to clarify the nature of participants' involvement were provided. After forms were signed they were collected. In the event they had questions about the study at a later date each participant was given a copy to keep.

Small group procedures: After obtaining consent from each of the participants I described the purpose of the group, described how we would proceed and provided an overview of 'rules' for group behaviour. These rules are outlined in the Small Group Interview Protocol (Appendix 1) and included the comment that, in this study, there were no wrong answers to the questions being asked, a request that one person speak at a time, an indication that each person would be given an opportunity to respond to each question and a request that comments made by individual participants were not to be discussed outside of the group.

With one exception, the group interviews were conducted in English. In one group one woman had very limited English, as such, it was decided that the whole group interview would be conducted in Spanish and then translated into English by an interpreter. That is, I posed questions in English, these were translated into Spanish, each participant, regardless of their English language abilities, responded in Spanish, and their response was then

translated. In this way all of the participants in this group were aware of what other participants were saying as well as what I was asking or how I was responding. In another group one participant was offered and accepted simultaneous interpretation so she could participate in the interview.

A series of trigger questions, as outlined in the Small Group Interview Protocol, (Appendix 1) were asked. The questions related to the participant's history of migration, general approaches to drawing on, or participating in, the resources of the community, challenges faced in accessing health services, approaches to maintaining connection with their home country or traditions and perspectives on parenting teenagers in a new cultural context. Each person was invited to respond to each question in turn. Following this, if individuals wanted to discuss a particular topic more fully they would be given an opportunity for doing so. All groups responded to the same questions although the format varied somewhat depending upon the size of the group and topics introduced in the women's responses.

The time for the group interview depended to a large part on the numbers of people participating and whether translation was required. The length of the groups varied from two hours to three hours and fifteen minutes.

All small group interviews were audiotape recorded and later transcribed for analysis. Field notes recording such observations as numbers of persons familiar to one another, responses to phrasing of questions, notes regarding areas or topics prompting indepth discussion, languages being spoken between participants etc. were made following the group interview.

Home Interviews

As noted above, small group interviews were followed by joint and/or individual interviews with the women and their daughters in their home or an alternative site which was preferred by them. With the exception of one woman, all of the women who participated in the groups participated in the follow up interviews. The reason one woman did not participate was because I did not have an interpreter who could accompany me to her home. The intention of the individual interviews was to expand upon the topics and ideas explored in the small group interviews by discussing these in relation to families' unique experiences. Interview guides for the individual interviews with the mothers and daughters were developed (see Appendices 3 & 4). As bhabha notes, the family is the site where the local and social converge and new understandings are negotiated. Interviewing in the home provided an opportunity to consider the physical and social places where the work of

families is undertaken. As I too entered the family environment I could draw upon my observations to inform the ways in which topics were introduced or discussed.

Ethical considerations and consent: Prior to beginning the formal interview in the home I reviewed the purposes of the study and using the written introduction to the study and consent form, I explained the nature of the interview process and how data would be handled to maintain confidentiality. If the woman's daughter had expressed an interest in participating I reviewed the consent form with her in detail and obtained her written consent or assent depending upon the daughter's age. As the teens had not participated in research before I explained how interview data are used, why their views were important to me and emphasised that there were no right or wrong answers to the questions that would be asked. Finally, I explained that they were not obliged to participate and they could ask me to erase material from the tape if they wished. I also explained why I was tape recording the interviews and described in general how I would work with the information. Teens were invited to ask questions about me, or the study.

Individual and Joint Interview Process: Bourdieu and colleagues (1999, p. 620) inform us that the interview is best when it is undertaken as a conversation. This allows the interviewer to participate and assists in diminishing social distance. Further the interviewer does not set out to impose a structure as might be the case with a formal questionnaire. Rather the participants, knowing the researcher's interest, are given an opportunity to introduce topics of relevance.

As noted by Arksey (1998) there has been limited attention paid to the nature of joint interviewing in the literature. Although different approaches to joint interviewing have been employed the nature of data generated through joint interviews can be qualitatively different than that generated in individual interviews. Joint interviews, Arksey observes, are generally undertaken with persons known to one another, and persons who are usually in a family or caregiving relationship. The topic of interest in such research is one of joint concern, for example, how paid and unpaid work roles are negotiated within the family, or how illness of a particular family member or interviewee, is experienced and managed (Radley, 1994; Radley & Billig, 1996), how views of health are constructed (Backett, 1990, a,b) or health meanings and goals negotiated within a family context (Valach, Young & Lynam, 2002; Young et al, 2001). Although it is expected that each participant will hold a different viewpoint on the topic, joint interviews can create a context for gaining consensus on an

issue, or in some instances, illustrate the consequences of holding different views on the ways subsequent joint action, or decision making is undertaken by the interviewer.

In this study the joint interviews, when they occurred, also provided some data related to the joint exploration of the parent adolescent viewpoints. When I originally conceptualized the study I intended to interview the mothers and daughters separately. Although this was the process in the majority of the interviews, in several instances this did not happen, because the mothers specifically invited the daughters to join in from the outset. Part of their stated interest in being involved in the study was to involve someone, a professional, with an interest in youth in their daughters' lives. In two instances the mother wanted an opportunity to talk about the types of issues being explored in a joint way with her daughter and the researcher (London, Vancouver). In one of these instances the mother then asked the daughter to walk me to the bus. In this case the daughter took the opportunity to discuss some of the topics addressed in greater detail with me and to ask me for my opinion. In some instances the mothers invited their daughters to be present in order to help them to express themselves as they were not confident about their English language skills (London, Vancouver).

It was my impression that the data from the daughters were more detailed when gathered in the joint context because in addition to presenting their own viewpoint they responded to their mothers' perspectives and extended their explanations with examples for my benefit. This is consistent with what Arskey (1998) reports in that joint interviews, where rapport is established can produce richer data when the informants add to each others' stories, by providing details, examples and gaps in the 'story'. In a number of instances the mother might prompt the daughter to tell me about "the time.... "or similarly, the daughter might challenge the mother to share with me the story "about..." that might lend support to her view of the issue being explored.

I did not encounter the situations described by Radley (1988) or Pahl (1989) where the researchers were concerned about potential 'fall out' following joint interviews where disharmony was manifest or where the topic being explored identified a 'problem' the interviewees were not prepared to cope with. Building from lessons learned in earlier research (Lynam & Young, 2000, 2002) I decided that if joint interviews were preferred by the participants I would consider it a facilitated conversation between the mother and her daughter rather than directing the discussion towards myself. In this way the joint interviews differed from the small group as the discussion in these groups was largely directed by me and responses were directed to me. I considered adopting this approach as standard but, in

keeping with Bourdieu's position on interviews as conversation, I decided to let the women decide what form the home interviews should take.

I also gathered demographic data about each of the participants. I completed these forms (see Appendix 5) after each interview. These data were drawn upon to describe the participating families and the formal and informal resources they drew upon.

Key Informant Interviews

After group and individual interviews were completed and analysis of these data was underway interviews with key informants were undertaken. These participants offered a perspective on the ways in which formal and informal organizations were engaged in working with persons like those in the study. The key informants included front line community health professionals working with women and youth like those involved in this study, mid level managers of community health organizations with responsibilities for programme delivery, and 'head office' managers with responsibilities for budget, allocating resources to community based centres and, whose responsibilities included, interpreting or responding to policy decisions at the programme level. The key informants were invited to discuss what they saw to be the major issues to providing services for population groups like those involved in this study, what they viewed as priorities in working with such women or youth, and how the current policy context (priorities etc.) influenced (positively or negatively) their work within the community. Eight key informants participated in one to three interviews.

Sample size

Sample size in small group research depends in part on the diversity of perspectives being sought, the geographic locations of potential participants, and the complexity of the issues being addressed (Morgan, 1988). As I complemented the small group data with additional data sources Morgan's guidelines needed to be modified. In his experience Morgan notes that group size can range up to 12 participants and that the decision regarding the ideal number of participants should be based upon the saturation of the data, that is determined once the groups begin to echo the input of earlier groups. In small group research data saturation is often achieved after 4 groups (Morgan, 1988).

For this study the decision about saturation of code categories was made after analyses of individual interviews rather than the groups. Estimates about sample size for qualitative research using individual interviews as sources of data vary depending upon the depth or richness of data being gathered and the nature of concepts being explored. Morse

(1985) suggests that the criteria of appropriateness and adequacy be employed in determining sample size. I sought to achieve data saturation for both mothers and daughters in each country, so that data for the British group and for the Canadian group could be analysed separately. Participants were enrolled in the study until I determined that saturation of descriptive categories and themes were achieved in each country.

In total twenty-three mothers and two teenaged daughters participated in five small groups. Two of these groups were held in London, and one had seven participants while the other had three. In Vancouver three discussion groups were held. Two of these groups had three mothers participating. In one of these groups one daughter accompanied her mother, in the other group two daughters accompanied their mothers.

The daughters were offered the choice of participating in the group discussion or not. In one group the daughter decided not to participate. In the other, the two daughters opted to participate. Hence this group had five participants. Five women participated in the third group conducted in Vancouver.

In total thirty-nine home interviews with persons in the participating families were undertaken. Twenty mothers and 15 teenaged daughters participated in home interviews. Two mothers and a daughter participated in additional interviews. In addition, one husband and one teenaged son also participated. The follow-up interviews lasted from one to two and a half hours. Table 1 summarizes the numbers of participants in group and individual interviews by setting and country.

Table 1 - Summary of Participants by Country and Data Set

CANADA	Small Groups	Participated in Individual Interviews		
		Teens	Mothers	Others
	3	3	3	
	5*	3	3	
	5	3	5	1 son
Sub Totals	13	9	11	
BRITAIN	Small Groups	Participated in Individual Interviews		
		Teens	Mothers	Others
	7	6	6	1 father
	3	-	3	
Sub Totals	10	6	9	1
TOTALS	23	15	20	2

*Includes 2 teens

Also 8 Key informants participated in 1 – 3 interviews

Gaining entry to the field

In both Canada and Britain I made initial contacts with formal health care organizations in regions of London and Vancouver that had a high population of first generation immigrant families.

London

In London, entry to the field was gained via connections established with the Three Boroughs Primary Health Care Team. As noted earlier urban centres, particularly London, have been sites of settlement for a large majority of immigrants. The population profile between London Boroughs varies but the Boroughs in which I gathered data are estimated to include 30 - 40% ethnic minority populations (Alexander, 1999; Hillier, 1997; Silvera & Kaposi, 2000 and Key Informant Communication, May 1999; Dec. 2001).

The focus of my initial meeting with members of the team was to gain background information, to explore the role of the team, to ascertain the pattern of immigration to this region of the city, to gain information about the types of community based organizations in the region, and to gain their perspective on the health issues being faced and/or barriers influencing access to services. This information was used in making decisions about populations to include in my research. I also explored their mandate within the team and their approaches to working with the populations of concern. The multicultural team works on an outreach model, making contacts with new immigrants primarily through housing centres to which refugees are assigned, or by liaising with immigrant serving organizations. Their role includes providing information to refugees and immigrants regarding their rights, the resources available and in some instances assuming an advocacy role. The need for the latter might arise for example when a health care provider does not make provisions for interpreter services as the Local Health Authority does have an interpreter service available.

An ongoing concern of this Team is the vulnerability of youth and the difficulties families face in gaining access to the resources (health, education and social) in their communities because of barriers of language, lack of knowledge of the system, its policies or their rights and a lack of financial resources. In addition it was noted in the discussions that in the initial time post immigration the families were often relocated several times especially if initial housing was not optimum for the family size. Families would receive temporary housing but would need to relocate when alternative housing, often in different areas of the city, became available. Families were not always able to choose neighbourhoods on the basis of kin or friendship group availability, schools etc. Each relocation may also mean a change in physician access because physicians' (GP) contracts with the NHS are for a population within a defined geographic area.

At a second meeting held some months later this Team identified a number of immigrant serving organizations in the region that might be willing to assist me with recruitment of participants for the research. Following this I made contact with three organizations. In each organization I contacted the Executive Director and, over the telephone or in a meeting at the agency, I explained the goals of my research, the criteria for participation and nature of involvement of participants. In each instance the persons with whom I spoke expressed an interest in assisting me. I then forwarded materials describing the criteria for participation (see prototype Letter to Agencies Appendix 6). The Executive Director, or designate, in each case agreed to assume a role in recruiting by identifying people within their organization that met the eligibility criteria and inviting them to participate.

All organizations approached expressed an interest in participating. However, one voluntary organization in London did not end up participating in the study. The organization had had a major funding cut and a change in services. This was accompanied by staff turnover. After my first contact I had considerable difficulty making contact as the office had limited hours and no one responded to the telephone. However each time I was successful in contacting the agency I connected with a different staff person. While each expressed an interest when I made follow up calls I would begin again with a new person. After having sent letters and making follow up calls over a period of six months I decided this organization could not be of assistance.

Once people had expressed an interest in participating, a date, time and venue for the first group meeting was set. In each instance the group meeting was held in a local community meeting place, usually a meeting room at the immigrant serving organization.

Vancouver

Following procedures undertaken in London, I made preliminary contacts with the Community Health Centre in a region of the city that had a high immigrant population and one that reflected the diversity of the community in London. Also, I sought out neighbourhoods that had a similar socioeconomic profile to the participating neighbourhoods of London.

As with my experience in London, the Community Health Nurses at the Community Health Centre referred me to a local community based organization offering programmes to immigrant groups. As I had in London, I provided each organization with a description of the proposed study, recruitment criteria and the nature of involvement expected of participants.

The Executive Director or Board Member, in turn offered to assist me in recruiting participants for my study. The group meetings were held in settings that were available to participants. In one case the meeting was in a room at the University, one was in a community centre meeting room and the third was in a woman's home.

Key Informant Interviews

After the interviews with mothers and daughters were completed and coding started, key informants from different sectors of the health care system, as described above, were invited to participate in interviews. Several of these interviews focussed in detail upon the informants' views of the intersection between services and the types of issues raised in individual interviews.

For example, an interview with a Health Visitor in London focussed considerable attention on the difficulties she encountered in her practice in attempting to provide services or mobilize resources for immigrant women or teens. Her perspective allowed me to both draw attention to local practices and ways these are constrained by policy and also illustrate how policy can be interpreted in different contexts. Her accounts also provided examples of conditions under which structural constraints can be challenged. Interviews with key informants in the informal sector provided additional insights into the role they envisioned voluntary organizations could play in increasing access to health care services as did interviews with those in policy development roles. Interviews with key informants in different practice or administrative roles enabled me to explore ways they were acting upon emerging policy decisions and to identify the challenges or dilemmas they were facing or the dilemmas they encountered when the transition from policy mandate to practice was short and while they might support the policy direction because of the timelines between implementation and evaluation they were having difficulty demonstrating the impact of programme initiatives.

Steps Taken in Analysing the Data

Immediately following each group and home interview I recorded field notes. These notes included questions for follow up in individual interviews and impressions of the researcher regarding data elements that were unexpected or that were immediately consistent with previous research or with the literature.

All interviews with study participants were audiotaped, as were some of the field notes. The majority of key informant interviews were not audio-taped but field notes were recorded during these interviews. All audio-tapes and field notes were transcribed with code

names being assigned to all people and sites involved. These transcriptions became the data submitted to analysis. In the chapters that follow excerpts from the transcripts are drawn upon to illustrate the conceptualization of different aspects of the participants' experiences.

Level One Analysis

Transcription

I employed an experienced typist to transcribe the study data. This transcriptionist has considerable experience in working with data gathered in group contexts and from participants with different abilities in speaking English. She is also familiar with guidelines regarding confidentiality of data. Before giving tapes to the typist, I assigned each a code number that indicated site, case family, participant and type of interview. If names were mentioned on the tape, the typist did not include these in the transcript. In these ways confidentiality of the data was maintained. After transcripts were typed each was reviewed against the audio-tape by the investigator to ensure accuracy. These first steps of transcribing and review Sandelowski (1994) views to be so important that she has characterized them as the first steps of analysis.

Transcription is itself a process of interpretation. In presenting the data in typed form I took direction from the decisions Bourdieu made in his work.

> "Transcription then, means writing, in the sense of rewriting...There are hesitations, repetitions, sentences interrupted and prolonged by gestures, looks, sighs, or exclamations...It is therefore, in the name of the respect due to the author that, paradoxically, we have sometimes had to rid the transcribed text of certain add-on developments, certain confused phrases, several expletives...which, even if they give their particular color to the oral discourse and fulfill an important function in communication...nevertheless have the effect of confusing and obscuring the transcription" (Bourdieu, et al, 1999, p. 623).

When transcripts were reviewed against the audio-tapes I corrected any gaps, but I also added or deleted punctuation to better reflect the participants' emphasis or my own.

Coding and Re-Presenting Viewpoints

After all transcripts were read and initial ideas noted and summaries of each transcript were made they were re-read and more detailed coding began. General code categories were developed from first interviews and were used and refined in coding subsequent interviews.

All interviews were then re-read and coded by hand with the most detailed lists of codes and related categories. At the outset 38 code categories were identified. These basic categories (such as migration stories, downward mobility, neighbourhood safety, violence and responding to violence, being assigned to the margins, intergenerational relations, etc.) developed as the data were gathered and concurrently analysed. As the conceptual picture from the data emerged, some of the original categories were combined with others to reflect the ways the participants' experiences were being understood. Appendix 7 provides a list of the code categories and sub-codes.

Following coding by category, all interviews were then re-read as individual units and summary narratives of key points of history and context were made. These latter summaries allowed data sets to be drawn upon as individual cases. That is, all data related to a mother and daughter were considered one case. These summaries and demographic data gathered for each set of participants were used to provide background information and define different contexts. The demographic data were entered into a summary table so they could be referenced to participants.

In addition, as the process of coding and analysis was a reflective process, I kept a journal of questions and ideas that occurred to me as I was interviewing, reading, and reflecting on the analysis. Some of these notes were flagged as Theoretical Memos. Appendix 8 includes an example of the ways such ideas were noted in the progress of the study.

After initial code categories were developed all interviews and code categories were entered on N*VIVO (Richards, 1999). However, when the process of writing began, I returned to the whole coded transcripts when drawing out data references as this provided the most complete context. After the analysis chapters were drafted, the whole data set was re-read and references to data were double checked with the original data set for accuracy.

Descriptive categories were then drawn upon to illustrate core processes or issues. For example, one category was Teens' viewpoints on Family Relationships, sub-categories included: pleas for privacy, pleas for support, seeking affirmation, seeking engagement, perspectives on parental actions, seeking to redefine relationship, teens explain differing parent teen perspectives – two world views. This coding of data produced a descriptive level of analysis. In this case the category 'Teens' Viewpoints' was considered with coded categories illustrating parental views on relationships.

The initial analysis, reflective notes and memos were then drawn upon in presenting the broader analysis. Data from each country was coded for saturation so that they could be treated as independent units. The main categories were the same for each data set, the

differences related to the variations within categories. For example, all participants spoke about marginalizing practices, with some viewing it as limited to particular contexts while others saw it as pervasive.

Bourdieu's concepts of field, *habitus* and capital were then drawn upon to offer insights into processes influencing relationships. This analysis formed the basis for Chapter Five, Intersecting and Diverging Fields: Dynamics of Intercultural and Intergenerational Relations. In drawing upon the transcribed data in presenting the analysis I made an effort to attend to the rhythm and context of the conversations. Therefore in many cases in the analysis I use extensive quotes. In some instances explanatory comments, such as referents are included in brackets and cuts, usually because the discussion digressed to other topics, or we were interrupted, have been indicated with ellipses. In several cases the comments are somewhat awkwardly phrased, these have not been polished because as the participants were being interviewed in their second languages such phrasing does reflect their use of language. In this study language, as a social marker, becomes a dimension of the analysis. The participants' phrasing and expressions also provide an indication of the range of English language fluency among the participants interviewed.

At the same time however I have worked to protect the context in an effort, as Bourdieu describes it, to "do justice to the remarks without entering into the reasoning, without accepting the reasoning" or obscuring the participants' logic (Bourdieu et al, 1999, p. 623). That is, I have made an attempt to ensure the comments of the parents and teens as represented in the thesis reflect their own explanatory perspective of events.

In drawing upon narrative data as this study does, Bourdieu charges the analyst with the mandate of transmitting

> "to readers the means of developing an attitude towards the words they are about to read which will make sense of them, which rest on the respondents' *raison d'être* and their necessity; or more precisely, to situate themselves at the point in social space from which all the respondent's views over that space emanate, which is to say that place in which this particular worldview becomes self-evident, necessary, taken for granted (Bourdieu et al, 1999, p. 625).

I have sought to accomplish this by including statements about the context of the participants' comments and in many instances by using several quotes that illustrate the processes whereby participants' justified or accounted for their own explanatory processes.

Addressing Issues of Reliability and Validity: Meeting the Criteria of Rigor

As noted by a number of theorists employing qualitative methodology, approaches to determining reliability and validity in qualitative research differ from those applied in quantitative research. Reliability and validity in qualitative work is appraised according to standards of rigor established for research employing qualitative methods.

Hall and Stevens (1991) have proposed a number of criteria that include appraising the congruity of methods and theoretical stance taken by the researcher. They take the position that tenets underlying feminist research must be upheld in the research approaches employed. For example, they argue feminist research should reflect concerns of particular groups of women, be undertaken for the purposes of finding answers for women, and in undertaking feminist research the researcher's history, assumptions and interpretations are scrutinized in the course of the study. They advocate a strongly reflexive stance be taken. Moreover, in undertaking the research and in analysing data the researcher "acknowledges the validity of multiple realities, woven by historical, contextual, and relational factors. Its assumptions predicate a perspectival quality to knowledge, which makes knowledge relative to the stance, environment and experience of the knower" (Hall & Stevens, 1991, p. 18). I have sought throughout this study and when representing it in writing in this thesis to make clear the links between the conceptualization of the problem of interest, the perspective to be taken in its examination and the methods employed in data gathering and analysis visible.

Bourdieu sets a number of conditions for ensuring the scientific integrity of research undertaken with direction from his methodological perspective. "Rigor, in this case, lies in the permanent control of the point of view, which is continually affirmed in the details of the writing (the fact, for example, of saying 'her school' not 'the school'" (Bourdieu et al, 1999, p. 625). In an effort to adhere to Bourdieu's condition in presenting and analysing the participants' accounts I have sought to ensure the reader is aware of who is speaking and, where possible, have drawn links between their thoughts and the conditions that have shaped the viewpoint being taken.

The Second Level of Analysis: Considering Implications for Policy

Several chapters of this thesis are devoted to examining the study participants' accounts. The analysis then proceeds in Chapter 7 to bring the women's perspectives together with the policy perspectives in order to illustrate ways women's experiences are socially organized or influenced by the broader social context. In undertaking this task in the analysis I seek to adhere to the tenets of the theoretical perspective. That is, as has been described in earlier chapters, the analysis views "women's everyday experiences as

inextricably connected to the larger political, social and economic environment. Situating investigations in their broader historical, sociopolitical contexts is considered a necessary condition for an adequate science of women's lives" (Hall & Stevens, 1991, p. 18).

Throughout the analysis I draw upon Bourdieu's concepts which provide a lens for understanding or assigning meaning to the accounts. Drawing upon theory to inform the analysis is consistent with a critical interpretive perspective. For, although I begin with the women's experiences, as Smith (1987a) has argued:

> "ethnography does not here mean, as it sometimes does in sociology, restriction to methods of observation and interviewing. It is rather a commitment to investigation and explication of how 'it' actually is, of how 'it' actually works, of actual practices and relations...Though women are indeed the expert practitioners of their everyday worlds, the notion of the everyday world as problematic assumes that disclosure of the extralocal determinations of our experience does not lie within the scope of everyday practices... The coordination of institutional processes is mediated ideologically" (p.160-61).

So, while Bourdieu challenges the researcher to make visible the different and sometimes competing stories or accounts of participants, he also argues that the analyst must make visible the broader social processes that organize peoples' experiences. His concepts are therefore drawn upon as a means of interpreting the participants' accounts. For example, when mothers talked about the consequences of downward mobility and the difficulties they faced in securing employment that recognized their previous work or educational experience, Bourdieu's conceptualization of the conditions that make capital hold or accrue value were drawn upon. This directed the analysis to recognize that "forces that are active in the field... are those that define the specific capital. *A capital does not exist and function except in relation to a field"* (Bourdieu & Wacquant, 1992, p. 101). This guided the analysis to proceed away from simple appraisals of women's credentials towards an examination of the social processes that create the expectations that immigrant women will participate in society in particular ways and their relationships with others will be facilitated or limited in particular ways. It is for these reasons policy documents are considered data and incorporated into the analysis.

Considering Women's Experiences in Relation to Policy

Taking direction from Smith and Bourdieu concepts central to the participants' experiences are drawn upon to prompt questions being asked 'of' policy. That is, in this case the concepts of marginalization and exclusion were central to the participants' experiences.

This then prompts the exploration of the ideological premises underpinning policy that may contribute to, or diminish, such experiences. The examination traces the ways these premises are taken up in different policy discourses and can identify points of departure from the overriding ideological commitment. In this phase of analysis documents, or texts, are considered data sources.

Such documents, Smith (1990) contends, are 'ideologically structured'. That is, created out of a mediating process that involved conceptualising and representing their ideological premises as 'facts' in text. For Smith, the problematic is that unless the conceptual and/or ideological structures are queried to demonstrate they actually explicate "an actual social organization underlying their sociological expression" (1990, p, 50) they may preclude the "development of a body of knowledge resulting from the explication and theorizing of the actual relations coordinating the particular sites of peoples' lives" (p. 50). Smith argues that attempts must be made to ground theorizing in *actual* social relations as a means for identifying whether the ideology serves the interests of all groups.

Smith (1987a,b; 1990) points out that as policy plays a role in the creation of individuals' experiences it is important to have a means for considering what policy change might be advocated to improve such experiences. In this regard these study data draw attention to the ways ideology of official texts attend to such experiences. As Smith (1990) notes:

> "textual realities are not fictions or falsehoods; they are normal, integral and indeed essential features of the relations and apparatus' of ruling – state and administrative apparatuses, management, professional organizations and other discourses" (p. 83).

The organization of such facts, such representations, in texts

> "presuppose an organization of power...and the uses of the organization to enforce processes producing a version of the world that is...known only from within the modes of ruling, and that defines the objects of its power" (Smith, 1990, p. 84).

Such objectified bodies of knowledge, sets of facts, or representations Smith contends, are known by the members of the relevant discourse.

What is at issue however, is that such discourses or representations of fact, and the generally unexamined structures that create and sustain them, may eclipse, or in some instances challenge, the authority and therefore the credibility of alternative viewpoints. Here as noted earlier, Smith's analysis diverges from Giddens'. While Giddens (1984, 1991, 1997) also analyses structure it is his view that structures are not constraints on action. But,

while Smith's work recognizes that structures can facilitate action, it is generally the action/goals/intentions of those who create them. For those 'outside' of this process, the disjuncture becomes evident when people find they must discount their own experiences because they are not deemed relevant, 'real' or of interest. It is this discounting that creates feelings of being 'invisible' or 'invalid' or in the case of our teens and their parents, of being unimportant, or of lesser value.

Smith's (1990) work has drawn attention to situations in which "the thread of invalidation or discounting recurs again and again in experiential accounts" (p. 133). Invalidation, in ways similar to the accounts of participants in this research, was central to the experiences of women in a number of Smith's studies, as a result of the ways they were viewed or conceptualized in a particular context.

For Smith, the researcher's task is to both make visible women's standpoint - their lived realities - to identify the points of articulation and disjuncture of these experiences from the (formalised) textual representations (discourses) and to use these accounts to reinscribe the relations of ruling to lend authority to these voices. Here, engaging in critique and reflection becomes a central purpose for as professionals, or scientists, we are part of the apparatus we seek to examine. Women's accounts of their experiences are drawn upon by the researcher to become, in effect, points of entry into the formal dialogue or tools for engaging in the development of new discourses.

Sampling of policy documents followed principles of purposive sampling. That is, as the study was concerned with health (broadly defined) the central health policy documents identifying priorities in health and mechanisms for health care delivery provided the starting point for document review. In addition however, as each country assigns jurisdiction for different levels of policy implementation it was important to also include policies relevant to such sectors. As well, because the participants' status as immigrant women had important influences on how they located themselves within their new communities and how they were 'located' by others, policies and commissioned research studies that were meant to be taken up in the health agenda were examined. Examples of the latter include the ways the policies of the Social Exclusion Unit (SEU) were taken up within health policy discourse in Britain.

The process of sampling policy documents therefore began by examining current health policy publications, working papers, commissioned inquiries (Britain) and Royal Commissions (Canada) that articulated the central premises of each country's national health policy. As well, government commissioned studies that had as their focus the health of, or health services for, ethnic minority populations, health inequalities (Britain) and equity or

access for immigrant groups (Canada) were examined (Canada, 1988a; Alexander, 1999; Nazroo, 1999).

As suggested when literature related to approaches to policy analysis was reviewed the analysis of policy (documents) can be undertaken in a variety of ways and for a variety of purposes. The intention here, following from Bourdieu and Smith, is to examine policies and discuss these in relation to the concepts central to the experiences of the study participants. As suggested in Chapter 2 in the review of literature that focussed on health inequalities, different ideological or conceptual stances are associated with different types of policy interventions. Implications of the policy analysis to be undertaken here will be examined in relation to the discourses on health inequalities and discourses on culture and health.

In determining the adequacy of the chosen interpretive framework, Smith (1987a) argues questions of validity "involve references back to those processes themselves as issues of " 'Does it indeed work that way?' or 'Is it indeed so?' " (p. 160). Therefore, in deciding whether the interpretive framework employed in a study is adequate, it is necessary to ensure the tenets of the method and approaches to analysis are consistent with the theoretical perspective taken. Also however, in presenting the analysis, the analyst must make visible the ways in which data and the interpretive framework were drawn upon in presenting the argument. The test of adequacy in achieving these criteria will be determined by how these principles are adhered to in the chapters that follow.

Summary

In this chapter I have outlined the principles I sought to adhere to in undertaking the study and described the methods employed to gain entry to the field of inquiry and how data analysis was undertaken. In each of the analysis chapters that follow I have included greater detail about decisions made in the process of analysis and have provided examples to illustrate the ways I arrived at the interpretation presented.

Four chapters in this thesis have been devoted to the presentation of the analysis and interpretation of the study data. Chapter 4 presents an analysis of the participants' migration experiences with a focus on Bourdieu's concepts of field and *habitus;* Chapter 5 examines the dynamics of intercultural and intergenerational relations. In undertaking this examination I draw upon Bourdieu's concepts of field and capital to focus particular attention on the difficulties the teens face. Chapter 6 focuses on processes of marginalization building from Smith's contention that women's experiences are socially organized, or shaped by institutional processes and practices. In each chapter I draw attention to ways this takes

place. These chapters are followed by a discussion of findings in relation to theory. Here I also discuss the implications for policy and practice.

Chapter 4

Stories of Migration - Expanding Field & Transforming Habitus

In this Chapter I draw upon the study data to illustrate the migration experiences of the participants as they illustrate the participants' point of entry to the community. In presenting this component of the analysis I take direction from Bourdieu's concepts of field, *habitus* and capital in order to focus upon the contexts within which the participants were located.

In order to attend to the dynamics operating within fields I provide examples of situations in which the participants were constructed by other people and in some instances by themselves as 'others', as 'outsiders', as persons who were viewed as not sharing *habitus* or were deemed to be without the necessary capital to navigate the social context. Additionally, the migration stories illustrate efforts made towards transforming *habitus* to acquire competencies demanded in the new social context.

As the concepts of field, *habitus* and capital are conceptually linked, this section introduces the role of capital in negotiating entry to fields which will be examined in Chapter 6 and raises issues related to the processes of marginalization that will be explored more fully in Chapter 7.

Revisiting *Habitus*

Although *habitus* has been discussed at different points throughout this thesis I reiterate here a representation of it that emphasizes its location and influence. That is, *habitus* is a feature of the individual which is a product of his or her own history that is drawn upon to guide social interactions. Bourdieu characterizes *habitus as* "a structuring mechanism that operates from within agents... it is *habitus* that creates or contributes to a predictability of actions" (Bourdieu & Wacquant, 1992, p. 18). *Habitus* is historically constituted, institutionally grounded and socially variable (Bourdieu & Wacquant, 1992, p. 19). As such, in this study although all participants were immigrants, it cannot be assumed that they shared the same *habitus.* For example, although many participants spoke the same languages, their countries of origin differed and therefore the socio-political contexts within which traditions assumed to have similar roots were enacted also varied. Furthermore, the participants had moved to two different countries and had done so through different avenues. By analysing their perspectives on field and *habitus,* it is possible to gain insights into how social structures influence the ways in which *habitus* was redefined or transformed and to understand the nature of the conditions that constrained or fostered the participants' abilities to participate in different fields.

The assumptions of one's *habitus* are challenged in new social contexts. As such, it is to be anticipated that there will be social fields in which the study participants are prompted to re-examine their *habitus*. Additionally however, as bhabha (1994) has argued the home-family context is a site for the renegotiation of cultural meanings. This theoretical framework directs us to consider that as individual family members move into new fields, some of which may not be shared by other family members, as well as being challenged from without, the family *habitus* and associated expectations, rules or conventions may be challenged from within.

Migration Stories

The decision to migrate was effectively a decision to move to a country with a markedly different social and political climate. The decision to migrate was, for the majority of participants, prompted by a desire to escape oppression. In all cases oppression is recounted by participants as related to systematic (institutional) use of power to limit freedoms and/or to constrain living and working conditions. In some cases the oppression experienced by the participants in their home countries was compounded by the status of women within the cultural context. The forms of oppression experienced by the participants varied but included, oppressive social climates in which freedom of speech was curtailed, where violence was used to silence resistance and where women, or in some instances women and minority groups within the country, were not accorded the same rights as others and so they and their children were likely to face exploitation and/or a lifetime of poverty.

In migrating, most families were seeking an opportunity to live without fear in countries that respected human rights. Migration posed many challenges for the participants including the need to learn how to access the workforce and to navigate the education and health care systems. Participants also recounted their experiences of determining what social skills would facilitate their being able to begin to establish new friendships and relationships and become a part of their new communities. These imperatives were overlaid by the need for families to gain an understanding of the ways a physical place was organized and the programmes and services available. Additionally, while a number of the participants had some English language skills, all the women who participated in the research recounted that at the time of migration they needed to develop their facility in English.

All of the women viewed immigration as offering a possibility of making a new life for themselves and their children. That is, Canada and Britain were viewed as offering the possibility of employment for themselves and education for their children, that staying in their home country did not. While their stories offer insight into the turmoil and uncertainty

of migration they also offer examples that would evoke images of the creative possibilities that bhabha (1994) writes of.

The Decision to Migrate: Seeking a Safe Haven

For a number of families participating in the study in Britain the decision to migrate was prompted by threats to the family's physical and psychological safety. Several participants reported that in their own country they had been under surveillance and had their lives or the lives of family members threatened with violence or had been living in an active war zone. In some instances the decision to move was quickly made after such threats were enacted. Such families often had limited information about countries in which they could find safe haven. Decisions about where to go were usually made because they had knowledge of others living in either Canada or Britain.

For several other families in Canada and Britain the decision to move was influenced by unrest in both the political and social climates of their home countries and the view that if they stayed home, particularly as women, they would not be able to safely manage to work and care for their children. Two families moved in anticipation of a change in status when their country reverted from being a British Crown Colony to Communist Chinese rule. In these cases the pending government change was viewed as a threat to their social position and possibly a threat to accrued financial resources. In one of these cases, the mother established residence with her children in order to gain citizenship with the original intention of returning to her home country. However, the family situation changed during this time, in that her husband sought a divorce. After a brief return to her home country this woman chose to return to, and remain in, Canada because she viewed it as offering the possibility of a new life without the stigma of divorce she would have faced at home and because her financial resources would allow her to maintain a higher standard of living in Canada than in her country of origin.

Mother - I can say Canada is a good, I mean Vancouver is quite nice, um, how do I say like, um, for the first few years I hate it here. I think ooh, I, I like to go back to Hong Kong, but when I went back to Hong Kong I feel the place does not belong to me anymore.

res - so then you're

Mother - Yeah, and then I think oh, for my children's sake and for myself's sake, then I better come back here.

res - uh, hum

Mother - and that's it (laughing) because air pollution make me. Not only because of that like, uh, I mean just naturally, lots of things like I, I was afraid of how the relative and, friends,

res - they look?

Mother - yeah, how they look, look at me.

res - because of the divorce you mean?

mother - Yeah, and also divorce and some things like that and also, like, um, for that, I mean for the last ten years, not only ten years ago, I mean I can see Hong Kong change a lot, the economy and then troops and (laughs) um,

res - So, it's not the place you remember it to be or that you feel

Mother - No, I feel like a free - pause.....

Mother - I'm okay, drop back, Canada, I mean Vancouver. Of course, everywhere they put nice people and also mean people.

res - uh, hum

Mother - But I have to stand up (laughing). What else I can do? I mean if people don't - they look down on me then I don't care, I don't have to borrow money from them right?...

> Mother - primary school help them a lot...because the classmates, they never ask you, you have a dad? or something like that, right? They (meaning classmates) don't care as long as they get along (group interview 40, Canada, participant, 42 p.25-6).

As she speaks in the group about her reasons for migrating, this mother provides an overview of the pending social and political change in Hong Kong. She also however alludes to the stigma of being a single parent as a consequence of her divorce. She observes, in Canada, her children were not subject to questioning about the legitimacy of the family. Finally, she suggests that in Canada she has to "stand up" to, and cope with, other's disdain if it is forthcoming. She is able to do this in Canada in part because she isn't dependent upon them. As such, for this woman although initially immigrating was not her first choice Canada became a preferred social context for the family; a context that was in her view more accepting of the family situation.

For three families, two in Canada and one in the Britain, the decision to immigrate was prompted by families choosing to pursue career opportunities that became available in the new countries. One woman's husband qualified in a work role that was in demand in Canada; they therefore decided to move. In speaking about the impact of the move this woman saw it as providing opportunities, particularly in terms of the quality of family life,

that they would not have had had they stayed in Hong Kong. For the second family the chance to live in London- 'a city of the world'- that was created through the father's work was viewed as an educational opportunity for the whole family, an opportunity that nonetheless created major disruption in the woman's ability to find a way to use her education and work experience in a work role in the Britain. The third family embarked upon the move as an adventure. While the husband in this family was described as happy, immigration made his wife realize the extent to which her day to day life, which was centred around extended family and was very happy, had dissolved in this new country. This was a change she had a great deal of difficulty accepting.

These participants' accounts of the decision to migrate draw attention to the ways in which the social and political climate and socially determined rights and roles define the nature of family life. What is most striking about the accounts is that their 'place', opportunities, rights, roles and the expectations held of them, or assigned to them by others were largely gendered.

Bourdieu (1994) in discussing patterns of social organization, as reflected in day to day realities, observed "the organization of the existence of the men and the women in accordance with different times and different places constitutes two interchangeable ways of securing separation and hierarchization of the male and female worlds" (p. 159). For the women in this study, immigration to Britain or Canada held out the possibility that their social position, and that of their daughters, would be markedly restructured.

Profile of Participants:

Family Structure, Material and Social Circumstances

Of the 21 women who participated in the group interviews five were separated or divorced, two were widows and the remainder were married or living with a partner at the time of the interviews. The women who participated had a range of educational backgrounds and had varied work experience in their home countries. The group included two participants who had completed or undertaken part of medical training, one with a post-graduate degree, two with degrees in social work, two with accounting credentials, and several with different levels of nursing credentials in their home country. There were also several women with less than high school education.

With one exception, and this was after four years of taking additional English language courses, courses related to her field and having undertaken voluntary work in the field while also working and being the head of household with three children, none of the women with credentials had been successful in obtaining employment in their field. Some

were employed in related fields. For example, one woman with a nursing background was working as a medical receptionist. Others were exploring ways to upgrade their credentials to be able to work in the fields in which they had experience.

Although some women were disappointed about this downward mobility, others viewed it as part of the cost of migration. That is, the decision to migrate was a decision made for the safety of the family and to ensure a future for their children. They envisioned their children would have more success in accessing careers through education.

One woman explained that once she had decided to immigrate she settled her daughters with family in Canada and then commuted back and forth to Hong Kong until she had her affairs in order and accumulated enough money to manage.

Mother - So and then, uh, I left the children here and then I go back and forth to Hong Kong and Vancouver - for - three years so I get to earn money and also I get to, uh, get my, I get my job, and get ready to move.

res - Right, so you were working in Hong Kong?

Mother - yeah

res - through all of this.

Mother - yeah

res - So, it would be difficult to be going back and forth

Mother - yeah

res - maintaining your contacts with your kids and starting to develop some connections here, I mean you had two, so many things happening at once

Mother - yeah... and when I decide to stay here I'm very happy, yeah, because, uh, I can leave Hong Kong, the place I'm - pause

res - all the problems

Woman and others in group agreeing.

Woman - yeah, so I'm very happy to live here and…second year I get a job but just, um, it's very difference with my former job. My former job is, uh, accountant...over thirty years in accounting.

Another group member - very experienced.

Woman - Yes, (laughing) and then, uh, but I come here I just, uh, just a worker, help worker in the sewing factory, the sewing factory, make like jeans.....(describes more about her work...)

res - but you're happy?

Woman - yeah, because I just, um, I leave my problems, so I, I begin my new life (laughs) yeah. So now, even though the work is very hard and very

difficult and very, um for me, for my age it is, um, it is not, not easy to catch up but I, I think I will try my best because I like..this is a new life for me (laughing) (40 group interview, participant 44, p. 31-2, Canada).

The Nature of Paid Work

This woman's story introduces us to the extent to which family problems produced both unhappiness and a willingness to engage in major change to create a distance from the difficulties and to pursue the possibility of starting a new life. A major consequence for the woman speaking above, who was both well educated and experienced, was that she was only able to gain access to the workforce at a markedly different level. In the interview she indicated the conditions of her first work role were not as good as her current one. While she seems ready to accept this in the follow-up interview, that was undertaken jointly with her daughter, the daughter makes similar observations and is somewhat critical of her mother for allowing herself to be taken advantage of by her co-workers. Her comments prompted me to explore this further.

res to daughter - What do you think of her (referring to mother's) work place?

Teen - The last one is, um, what's the last one, um, I, I did not really like her friends, (laughing).

res - because?

Teen - Because the class, some of them are just like, um, okay, she work hard and she was really working (pause)

res - and they took advantage of her?

Teen - Yes, I just did not like this.

res - uh hm

Teen - and I just told her about this and she said that, 'Okay, well, I can help the people so I just help them"...

res - They were saying, I need help or,

Teen - "I need help", "I can help you" okay?

res - So they took advantage of her good will?

Teen - Yes, and some of them are just like, talking about the other workers, the other workers.

res - so gossiping?

Teen - Yes, at their back and, What's the point? Is what I think. What's the point of talking of others, I don't like - They are working together and need

> to be in harmony situation there, what is it really, their friendships and, uh, all that. I think that's good spirit (44, Canada, int. # 2, joint, p. 17).

The daughter, who has had more knowledge of the Canadian context, goes on to describe how she encouraged her mother to seek work in her current workplace. Although she thinks it is sad that her mother is still underemployed, she thinks at least the move was for the better as she observes her mother to be happier. Additionally however, part of this teen's knowledge accrued from her own experiences at school and her part time job. She was therefore, attentive to signs that others were taking advantage of her mother's vulnerabilities. Such vulnerabilities she viewed as a consequence of her mother's limited knowledge of the culture of the workplace, her mother's tendency to serve others, the ways her language skills could distance her from others and her mother's desire to establish connections with others.

At the time of the interviews eighteen women were working in part or full time paid employment in such roles as domestic worker or cleaner, garment factory work, food services, book keeper, community service worker, or nursery assistant (early childhood day care). Three women were not working in paid employment. Each of these three was however taking courses, or involved in voluntary work in the community and their husbands were employed. A fourth woman who was a single parent managed on her divorce settlement and a fifth was receiving a disability pension.

Husbands' Paid Work Experiences

Women with husbands observed they also faced downward mobility and while the situation improved for some over time, it was a source of stress and concern for many families. In Britain for example one husband who had been a journalist in his home country had taken odd jobs for a number of years. At the time of the interview he was working part time as an interpreter for a law firm. A second husband who had been a politician and a supervisor in a factory was, like his wife who was a university educated professional, working as a cleaner. A British teen noted the constraints.

> Teen - For instance, if you were an accountant over there, you can't come here under the same job because you need to have papers for that...Instead here you have to do lorry jobs and that, so it's very difficult (01, Britain, int #1, p.18).

In Canada, one husband whose first job was in a fast food chain cooking hamburgers had, at the time of the interview, started to sell real estate (had become an estate agent). A second who had experience as a supervisor in the airline industry was working at an entry level position handling baggage. His wife recounts the impact of this for both of them.

Woman - When we come here, come over here, he needs to be start at the very base. So he's not that.. (searching for word)

res - happy?

Woman - Yes, not that happy.

res - and has that changed a bit or is he still a bit unhappy?

Woman - uh, right now because already three years.

res - and he's still at that base level?

> Woman - Yes, still at the base level but, of course, he change a little bit...I know it but for a certain extent I can't help you know, so personally I think I, I have some guilty feelings at the particular time but I don't know how (what) to say and I don't know how to help him (#43, interview 1, Canada, p. 13).

Impact of Downward Mobility on the Family

Another woman, in recounting their experiences after moving to Canada, noted the changes, both positive and negative, that accompanied migration and workplace uncertainties and how her husband's situation influenced her.

Woman - ..during those first three years I take care of them (my daughters) and cook the food and it's very happy, I, um, during those three years I do the same thing, I never go to work and at that time, my husband get one job, not very, um, not very high salary but half, but can, uh, can afford.

res - So you could manage?

Woman - yeah.

res - Was it work he wanted to do? Did he like the job or was it okay?

Woman - It was okay, but later he, the job, he is in the jewelry, because the boss wants to close the –

res - jewelry store?

Woman - The jewelry store, so he maybe, um , have no job at all so I think it's very, very, I don't want my husband to get depression so, okay, now I go to work part time. So I start to work part time but I still continue to learn English at school, evening. So, also I participate in the volunteer job and I think, um, because during that time, although I'm very poor, I, um, every, every Saturday I bring my children to the church and they, uh, this, uh, mainstream church, not the Chinese church so they can, um, learn their

English and have a good time to learn the other things like the recorder, like the other

res - instruments?

Woman – Yes (40, group interview, Canada, p. 37).

As the accounts above illustrate the husbands' experiences in the workplace influenced the family's resources and the family emotional environment. Drawing upon Bourdieu to interpret these experiences it is argued that the husbands' capital related to their work experience, like that of their wives, was not recognized or could not be drawn upon in the new work context. As noted, one husband's fluency in English and Spanish became credentials for new work. While his work as an interpreter created links with the legal system, his role or location in the workplace continued to be defined by his own history as a refugee.

Additionally however, as suggested by the two women speaking above, women had multiple roles in accommodating the changes associated with settlement and managing family life in this new context. Women - mothers were involved in exploring ways to stretch the family's financial resources and contribute to the family income. Women also felt some responsibility for mitigating the negative impact of their husband's experiences in the workplace in addition to taking on paid employment themselves. One part of managing included establishing connections with individuals, organizations and resources that were part of the broader community.

Two women, one in each country, were receiving benefits. Each of these women was a single parent although at the time of the interview one woman's daughter was in her late teens and had started to attend college. This woman lived with her older married daughter and grandchildren. She was receiving benefits for a work-related disability.

The families participating had from one to four children. Several of the participating families had both teenaged sons and daughters. The data therefore often include mothers' comparisons of their experiences with sons.

Profile of Teen Participants

The teenaged daughters who participated ranged in age from 12 to 19 years of age. All of the teens participated in the interviews in English and while some spoke with a noticeable accent all spoke fluently. All were attending school in English and five of these had been, or were currently, working in paid employment part time. All of those working indicated they used the funds earned to pay for their own social activities or expenses such as clothes or to save for, or pay, school related expenses if they were in college. In addition to

paying for her schooling and related expenses, one teen noted in her interview that she worked additional hours to ensure that she would be able to contribute to the family budget. Very few of the participants pursued interests like sports, art or music outside of school.

A few had been involved in organized sports associated with their schools (Canada). One family encouraged the teen to pursue swimming and other physical activities through a community programme (Britain) and one teen took dancing lessons (Canada). Two played musical instruments with one having achieved a high level of mastery through the Royal Conservatory. Several families had decided it was important the teen master the first language and be familiar with their cultural heritage so they attended language schools, usually on a Saturday. Several teens in both countries were involved in youth related activities with their church or a community centre. For the remaining teens non-school time was spent with friends and/or in part time jobs.

Financial Profile and Living Conditions

Five families in Canada, and two in Britain, indicated while they watched their money they were not unduly worried about managing financially. All other families participating had concerns about managing financially with a number living with such restricted funds that they worried about daily expenses including being able to pay food bills, to buy clothes or to heat their homes. The majority of the participating families lived in extremely modest accommodation with limited furnishings. The majority of these families lived in co-operative housing projects, low rent apartment/flats or in Council housing thereby reducing their housing expenses. In all these families children shared rooms (in most instances day rooms were converted to sleeping rooms) and in a number of homes children or adults slept on mats on the floor.

Families used a variety of means to stretch financial resources. These measures included becoming involved in community based voluntary organizations like the church to help children develop their English language skills, or to learn how to play a musical instrument or play a sport, having a telephone for emergency calls only, or a telephone that only accepted incoming calls, use of food banks as a source of free food to supplement purchased food, the use of free lunch programmes at schools, the use of free summer programmes in local parks, and the use of second hand stores and markets to acquire goods at a reduced cost.

In recounting their experience post migration the mothers spoke about how they learned to access resources needed to manage family life. In particular, securing adequate income was a challenge, but of equal importance was having time, and resources or capital

(financial, personal or social) to ensure children's developmental, educational and social needs were met.

Balancing Paid Work and Fulfilling Responsibilities to Children

With the exception of one family, none of the families with younger children used formal nursery care (child care). These families organized their work (i.e. one parent working nights with the other working days or evenings) to share childcare with their partner or another family member.

> res - Now your work (as a cleaner) is that in the evenings or is that during the day?
>
> Woman - evening, evening.
>
> res. So, does your husband, is your husband home in the evening then or?
>
> Woman - Uh no, my husband works every night too, my daughter (the teen participating in the study) is the one who takes
>
> res - takes the responsibility?
>
> Woman - yeah...(we) work through the night, I work from ten to five or six in the morning so, yeah, but not everyday, just two or three times a week so, yeah, but it is still hard. Because in the daytime I wish to sleep the whole day but I can't, I just sleep for two or three hours and then, mummy I'm home, mum, I need you, mum I need this, that sort of thing so I really can't sleep.
>
> res - right
>
> Woman - Anyway, you know, that's the life (23, interview 1, Canada, p. 24-5).

Or as a single mother of three recounted:

> Mother - Since I move to London I've been working really hard.
>
> res - What kind of work do you do (name)?
>
> Mother - Now I'm a nursery assistant, and I work in a rest home, but before I used to clean. I used to clean, and because it's low pay, I have to work many hours. I have to work less now but... (05, Britain, p. 7).

Later this mother indicated finding better work was a priority for her because:

> " I need time for my children and I decided at the beginning to try to study a lot to make sure, sure no period of suffering... Yes, I know we have a very hard time and we have to make many, many sacrifices like no buying clothes or this things or that, - pause - anything." (05, Britain, p.10 - 11).

For this family, the teen who participated was, like other teens in the study, responsible for overseeing her younger siblings on the weekends while her mother worked.

Mother - I actually need (daughter's) help...I have to work at that place on Saturdays and leave (teenaged daughter) with the other children.

res - (to daughter) So, you are working, you're working at home?

Teen - Yes.

res - Well, that's an important responsibility, don't you think?

Teen - Yes, but nobody really likes it (05, Britain, p. 12).

In all families the teenagers contributed in a variety of ways, including as noted above, providing childcare to younger siblings, or, particularly in families headed by single mothers, also providing a source of moral and financial support for their mothers.

Some teens became an intermediary between their parent and other formal systems. In the account that follows one teen discusses how she feels about playing the interpreter role for her mother.

res - Do you ever find yourself in a position where you're translating like, for the clinic or for the doctor or does she manage when she's there?

Teen - Um, there's many times where I've had to translate because concerning, concerning payment things like credit or bank or something like that, something which considers a little bit higher English.

res - Em um

Teen - But like the doctor she has, she can speak it (English) so, no, she's usually able to manage. And I always – sometimes it hurts my head because I'm like 'Mom, you can speak it,' and she says, 'no'. And then I get mad because I don't, - I get annoyed...Then I put myself in her position and go okay, she needs someone to help her...(but) you don't want to deal with those adult things or ...especially, complaining to a company (laughs) that's the number one thing." (22, Canada, int 1, pp 15- 16).

The teen went on to describe occasions when she was involved in interpreting for her mother to arrange to have electrical power reconnected or to deal with credit card companies. Such situations were problematic because she was not of legal age and so couldn't herself make contracts. She declares her desire to not be involved in "adult things" but is, nonetheless, the one in the family who is called upon to fulfill this role.

While fathers who did live with their wives/partners and children were involved in family life, for the most part the nature of their involvement was described by the participants as different from the roles played by the mothers. Husbands might for example, take children to the park, attend a meeting at one of the children's schools or play a role in sharing childcare or in overseeing the family if the wife was ill or away. In only two cases

were husbands/fathers described as equal partners in all family activities, including cooking, shopping and childcare. For the most part it was the mothers who assumed responsibility for organizing children's activities, organizing family meal preparation and overseeing family health and the majority contributed, through paid employment, to the family budget.

While it would seem that women whose husbands were working could choose to "supplement" the family income through paid work many women found this a difficult choice. For example, in one of the group interviews one woman recounted how, in the first week in Canada she had been offered work caring for another family's children. After a week however, one of her daughters became acutely ill. There was no one to look after her. As she put it:

> "This woman and her children can speak English, so many people can help them, my children didn't at that time and I had no one to look after her. Then I decided my priority was my children. I should stay home with them" (40, Group Interview, Canada).

So this mother indicated that although money was tight it was only when it appeared that her husband might lose his job that she re-entered the work force.

The issue of work competing with family responsibilities takes on special meaning when women are the sole parent. Those families headed by mothers alone seemed to face the greatest hardships. While the mothers were quite resourceful, juggling all of their responsibilities was difficult, and doing so with limited financial resources was an additional challenge. In addition, while several women had used immigration as a way to put distance between themselves and their spouses for some women the ex-husband was an additional source of stress.

A woman who had four children and was pregnant with her fifth, had left an abusive relationship. Although there was a restraining order against the husband, he had rights to have the children visit him. She was especially concerned about her teenaged daughter who participated in the study as she was having difficulties at school. The mother indicated several times in the interview that one of her major concerns was how this teen spent her time when she was at her father's. Although this mother had been working, her income barely covered her expenses and her work was during the evenings. She thus found it difficult to supervise her children.

> Mother - (talking about teen) - She didn't go to school because she, she got okay but in the middle of the year she missed some class, she told me she was going to school but all that time I was very busy working. I didn't have the time to stay at home and mostly my job was in the afternoon.

res - You were working afternoons so you didn't know?

Mother - Yeah, I don't know, I didn't know that she wasn't at the school and the counselor told me that she wasn't there and missed some classes and sometime I talk to them (the counselors or teachers at the school) pause (to ask them). What I was to do with her?

res - right

Mother - and they told me to talk to her - (ask her) what she wants to do, and I said she has to listen but she just -

res - uh hm

Mother - she didn't answer me any, anything and I don't know. I don't want to judge but sometimes it's the friends, you know, she was with some friends that I really don't like because they, what they do is, don't, they don't want to go to school and go, you know walking around...

res - So, you're worried about her?

Mother - Yes. I said, listen, you're supposed to have, I don't know if this is because of the breaking, you know, my marriage, and my separation. I know they have, they have been upset before that lots of violence in this house because my ex-husband he was drinking everyday and I don't know if that's the reason she has problems right now (Canada).

The accounts above point to the ways in which childcare concerns competed with the women's abilities to participate in the paid workforce and have the resources needed to deal with complex family issues.

The conditions of the women's work also constrained their abilities to be involved in the teens' lives in that the time devoted to work often made them unavailable and the scheduling of the type of work they were doing often coincided with the teen and other children's time outside of school. Hence, mothers spoke of being unavailable and sometimes only discovered after the fact that their teens were having difficulties. Where possible, families drew upon other family members for assistance. But, in most cases, the family network was very limited making it particularly difficult for single parents. As such teens were drawn into family caregiving roles.

Redefining the Social Network

While the mothers generally described their readiness to make the changes necessary for getting on in the new countries, such change was sometimes difficult for the teens. For example, in one family the mother described herself as "the kind of person that likes to change and to experience different things" (04, Britain, p.9). She sought out opportunities to

become a part of the community and became involved in working (as a volunteer) with a voluntary organization, work that was similar to the professional role she held in her own country. The importance of this work was underscored when she described the impact of migration on her social network. She said she felt her "social life becoming reduced" and experienced difficulty making friends. (04, Britain, p. 12)

On the other hand, her daughter, who was 11 at the time of immigration had difficulties and for years wanted to return.

> Mother - "She complains very often that why... we move her from her country to this country that doesn't belong to her....She says, we choose for her, we elect for her, she's needing the opportunity for her to choose the place where she wants to live" (04, Britain, p. 27).

So, within one family we see examples of the varying impact of migration and the challenges faced by different family members. Such challenges include navigating the margins. The mother in this case deployed her capital (career skills acquired in the home country) and knowledge of the disruption associated with migration, as credentials for a role within the voluntary organization thereby developing new connections and effectively transforming capital.

Her daughter, like other teens, is engaged in acquiring competencies or developing capital. This process includes deciding who they are and what their own strengths and competencies are - as well as exploring new fields. The teen participants, like peers of similar ages, want to achieve some 'distance' from their families. For many families the effect of this was that the parents were often excluded from fields of importance to teens.

Teens in general had quite limited connections particularly with adults outside of the immediate family or teachers at school. Teens therefore were attempting to navigate new fields largely without input, or guidance, from their parents or other adults. This exclusion and the processes of marginalization that contributed to it, which will be explored more fully in Chapter 7, can be seen to emerge from a number of conditions. These include limited community activities for teens, particularly teens who have not grown up familiar with resources of the community, the social location of the family - in the workforce, the family's lack of knowledge of, and involvement in systems of relevance to teens and the separation of youth and adult family social spheres or fields.

While the changed social location seemed to have the greatest impact on the parents' and teens' sense of connection, many parents also spoke about the health risks, usually issues of safety and concerns about sexuality, that were created and the difficulties they faced in mitigating them.

Other mothers' vulnerabilities were evident when they spoke of the limits on their abilities to supervise or guide their daughters because of the limits to their understanding of the contexts within which their daughters were growing up.

> Woman - She said although she's worried but at the moment her daughter is as good as gold...She comes home from school and she doesn't, you know, go out or, you know, I mean the daughter doesn't do, at the moment doesn't do anything that she have to concern about but it's always a worry, she said because of her difficulty with English. Even if the daughter say, oh, I'm going somewhere, you know, there's no way she can check (13, group 10, Britain, translator speaking).

These mothers were limited by a number of conditions operating in the fields. One that is evident is the lack of awareness of, and access to the culture of their children's peer groups. One context where some insights might be gained would be the school, but most parents experienced high schools as unwelcoming places where parents had a very limited role to play. Although there were formal, structured opportunities to 'meet the teachers' once or twice a year, most mothers felt uncomfortable attending. For some of the women this was perhaps due to their limited exposure to western education settings and therefore a lack of familiarity with what was expected of them, and what was reasonable to ask etc. This is similar to what Reay (1998a) describes in her work with working class parents in the Britain. Others were intimidated by the setting in that in order to participate they needed to be able to speak English in a large group. There is an additional consequence of not being familiar, that is, mothers found it difficult to guide their teens and to assist them to acquire competencies needed to navigate new fields of encounter. Whereas in countries of origin parents might have greater ease in navigating more fields, and teens by their accounts would have greater access to a network of adults and family.

The contrast was evident in this interview where the teen had been describing what life had been like for her in her home country compared to living in London.

> res - So, when you think of Peru –you think about relaxing and, having fun.
>
> Teen - and in Peru I could just be with my cousins and stuff.
>
> res - so, you miss some connections with family?
>
> Teen - Yes (05, Britain, p. 13).

This sense of disjuncture between parents' and teens' experiences was manifest in most of the interviews.

> Father - The young people they think in a very different way than the old people...but, um, I told her, her mother told her, we are fighting (striving to

succeed) and we are thinking that all she has to do is to study because it's the only opportunity she has to get a bright future. If you, if you don't do that, you are going nowhere (04, Britain, p. 29).

Comments like those made by the parents speaking above, delineate the nature of the challenges being faced by families. While most parents are concerned about the future for their children, the experiences for these families are shaped by additional forces.

A number of the teens had difficulties at school. For those who did not most parents admitted that they knew little about their children's school environment. As newcomers themselves many parents lacked the capital (or familiarity with how - *habitus*) to interface with formal systems such as schools. This combined with the culture of high schools in which the expectation is that parents' involvement will decrease made it very difficult for many parents to become familiar with the teens' day to day world.

Getting Settled: Families in the Community

The participants' accounts of their experiences of settlement were interwoven with their discussion of their current relationships (both formal and informal) within the community. That is stories of their initial time in Brtiain or Canada, and the responses of others around them at the time of migration, framed or shaped the ways they spoke of their current situation. Therefore even though some participants had been in Britain or Canada for more than 10 years the participants reflect back to earlier times to explain or account for current perspectives or activities. Participants who met the government's definition of refugee were eligible for, and received, settlement support from the formal sector. At the time of interviews however none was receiving support. Other participants drew primarily upon friends, family or resources of voluntary organizations following their immigration. In the majority of cases participants subsequently made contributions to the broader community and acknowledged that they did so in part out of appreciation for assistance and affirmation provided by others at the time of their immigration.

The following accounts illustrate several women's views of the importance of immediate family and the climate of the broader community in fostering settlement.

Mother- I think the most important point is that we have, we come with a whole family so it's more easy to adapt to life here and nowadays there are so many immigrants (30 group int. Canada, p. 24).

The diversity within the community is also seen as fostering a sense of connection.

Mother- Well you see whether we go to the supermarket, have friends together, work together. It never feels separate. (30, group int. Canada, p. 25)

This woman and others in this group spoke at length about their opportunities to participate in community events that honoured their culture and gave as examples the Dragon Boat Festival, or the autumn festival. One woman summarized the group's discussion:

> Mother- Yeah, I think, uh, Canada is a multicultural place, um, and no discrimination between us. (30 group int. Canada, p. 26).

Another woman described the settlement experience this way.

> res - Thinking back to when you first came to London and since that time, what are some of the resources, the way you used friends or family or the community or other resources to settle here? What were the things that were helpful to you when you started to settle?
>
> Woman - You mean support in whatever form?...Uh, for me, I escape Vietnam with my extended family, yeah, in um, we go in twenty, about twenty-three people including my cousin and uh, my own, I was single at the time and I escaped with my elder sister and grandfather and my father. He got no family, but his family was left in Vietnam, only my eldest sister, she got the whole family to escape with her so it seemed that, about the mental support, it seemed that I got that...When we first came because all of us we didn't know much about England...
>
> res -So when you, when you were settling though, your family was the most important resource to start with? The group of twenty?
>
> Woman: I think so. yes.
>
> res -So, how did you make your way, knowing how England works, how London works?
>
> Woman- Because while we were in the reception centre, we had to stay in the reception centre in the first place, for about a year. After a year they find accommodation for us. In that time we got support from Council, from Home Office, because reception centre is supported by Home Office...yeah, we wanted support so they gave us advice about welfare, about how to settle here, housing, different accommodation for us and education for children and adult education for adults learning English and find ways around (10 group interview, Britain).

Another woman, who immigrated to London in 1993, was able to draw upon the resources of the voluntary organization (10, group interview, Britain, #13). A third woman immigrated first to a smaller community in the U.K. faced different challenges.

Woman - When I first arrived, um, I spoke English so that's not the problem but, um my problem was living in (name of community) which is much smaller. There was no center so there's no networking.

res - There were no resources?

Woman - Yeah, no, no emotional support, um, practically, you know I have no problem but for that sort of thing then it was a problem because you don't know, you just first arrive in the country and you don't know who are the people and, um, you just couldn't make any friends really for about two years (10, group interview, Britain, 13).

The new context made women realize they had to approach making friends and getting along in new ways. Their expectations, their *habitus* was different from those around them. This influenced how they undertook their day to day activities as well as creating challenges in their efforts at making friends. While some women took the initiative to create resources for the community thereby extending their *habitus*, in the new context, for many these were transitional initiatives in that subsequently they sought to take their place in the broader community. These two women's experiences delineate a role for voluntary organizations as both a source of information and as a point of connection with the community. While being able to speak the language of their new country was an important asset there were other features of the migration experience that stood in the way of becoming part of the broader community.

One family's migration story recounted one crisis after another from difficulties with housing, violence in the community, teens facing school failure, underemployment, and the realization that they did not share the *habitus* of the extended family, or many of the people they had met since moving to Britain. As this mother spoke with me she, like others, was continually reviewing her choices, to consider, what if anything could she be doing differently, what options were available. This mother and others, asked themselves, and me, could they have anticipated (and avoided) the difficulties their children, their daughters in particular, were facing? The questioning that accompanied each revelation that things were 'different here' kept such families from feeling a part of the community and questioning whether there was a 'community'.

One Canadian family is involved in a church where the priest and much of the congregation are Spanish speaking. The teen describes the importance of this for her mother.

Teen -I think it is (important) because it would be very strange if you don't, if my mom didn't have any friends because her family doesn't live here, they all live in El

Salvador and different places in the US, but I think she needs someone to talk to as well, right?

res - Yes

Teen - Because I've made my friends in schools. She makes her friends in wherever she gathers…she also went to school…and she made a lot of like non-English speaking friends and, well, which is pretty cool because like that she gets adapted to having a multicultural relationship with people, you know, because they speak a different language but they could be in the same situation except with a different country (22, Canada, int 1, p.10).

For a number of participants, particularly those who migrated on their own, their initial connections were not through voluntary organizations. Rather, a number were made through activities of younger children. For others it appeared initial connections, which served as points of entry to both formal and informal resources, arose from chance occurrences.

Woman - um, I think it's around the first few days I always, in the morning I went with my son to have a walk in the morning. The first, uh, the first Saturday, I suddenly met a Chinese family, they had a girl and also a couple, the girl is the same age as my son.

res - as your son?

Woman - Yeah, and we did it the first day so also the first time that my son met a Chinese girls, he was very, very happy. He just approach the girl

res - right

Woman - and the girl approach him (laughing) so they just

res - connected with one another?

Woman - So happy together, yeah, so we both sat and talked and they spoke Cantonese. But they didn't live here (in this neighbourhood), they were just visiting their parents (in the neighbourhood). They have been...ten years in Vancouver and he know that oh, I'm just an, a new

res - a new immigrant?

Woman - A new one, yeah, so he just give me a number and say if you've got any questions, I can talk with them.

res - wow

Woman - yeah, and also he's a Christian, he also invite me to go to a church just near my area (21,int. 1, Canada, p. 9).

The woman went on to talk about how fortunate this meeting had been and indicated that in this instance she trusted her instincts that this was a safe encounter. She, like several other participants in the study, met and made friends with people with initial connections having been made through their young children. Their visibility as 'newcomers' was in part because of their physical features as Asian, but also because of language and mode of dress. For many of these young families, the families they established connections with, were themselves newcomers, and while many were from different countries, their experiences with migration were viewed as a common basis to begin a friendship.

Another woman, originally from El Salvador, whose country was in " so much trouble" and who had applied for refugee status at the border with her infant daughter had a similar experience. Prior to migrating she had knowledge of a woman who was living in Vancouver. However, when she went to the address she had for the woman she discovered that her contact was no longer living there.

> Woman - So I went there and she was not there in the building and I went to the manager and I asked, well maybe she didn't understood anything that I say (laughing) but I said that I was lookin' for her and then, um, I know that she told me that she was not there but I'm not saying she really understood what I say - but I imagine what she was saying - and then she went upstairs and showed me a unit that was two bedrooms, no, one bedroom and she told me that, uh, I can come here to stay so I understood that she was asking me to stay there, I was so happy and she phoned welfare and she filled out lots of paper with me and then talked to some people, phoned a number of place and they took me to welfare and they paid for the -
>
> res - rent?
>
> Woman – Yes (23, int. 1, Canada, p. 9).

While it would appear the preceding example was merely good fortune, the landlady was sympathetic to this woman's plight and familiar with the resources available to newcomers at that time and how to access them. Additionally however, prior to presenting herself at the border, this woman had informally gathered information from others in similar circumstances and therefore knew people who had been successful in the immigration process. Such information, while largely derived from informal sources, nonetheless provided her with information about how to reach the Canadian border and apply, and it also helped her to connect with people who were able to help her.

Shortly after she arrived this same woman went to a local church as she had been active in the church prior to immigrating.

Mother - When I first came here I look in the Yellow Pages™ (the advertising section of the telephone directory) for a church and I went to one church that was like six blocks from my house and one guy told me, oh, you speak Spanish, and I say, yes. So, I hardly understand him and what he's saying but I want to be here and he told me. "You're welcome here any time you want but you know, I know of a family that go to a church that is Spanish" and they, they took me to there and I live there. To the other church, so it was very nice. (23, interview 1, Canada, p. 30).

Church communities have continued to play an important role for this and several other families. While the family referred to above no longer attend services regularly, the family, both children and parents, have continued to be involved in church related activities. The teenaged daughter and younger siblings participated in the youth group.

res - Your church that you go to, um, you find that quite helpful to you as a community, right?

Mother - Yes I do.

res - Now is that in Vancouver, or in (suburb of Vancouver)?

Mother - Uh, no, no it's in (another suburb), before it was in Vancouver, because we (the church community) agree we work together with Canadian people, but now we are, before we were twenty (families) but now we are like seventy-three (families) so we need

res - a bigger space?

Mother - Yes, so we are in a bigger place.

res - So, it's a place where you can use your language and share your faith and so do you do other things? Like does the church do family things as well?

Mother - On Sunday morning, yes we have a, sports day so they play there, they have games, they have, uh, they have fun there (23, mother interview 1, Canada).

In many cases connections were initially made with others in their language community. However, in every case the participants looked for ways to establish connections outside of the language community. In this example they, as members of a church community, decided to "work together with Canadian people". Such organizations and groups became mechanisms for interfacing with the broader community.

The mother speaking above continues to draw upon her early experiences to ease others' transitions post migration. In the interview she offered examples of situations in

which she had explained the role of the community health nurse, or formal health programmes to others as well as providing information about programmes in the community that both helped people to develop skills and meet others.

> res - So it sounds like, I have a sense that a lot of people have been helpful to you, but I have a sense that you also have been helpful to a lot of people, do you see things going two ways?
>
> Woman - Well, yeah, I think so because when I, uh, meet people that don't know about any knitting, so kind of, here's some classes, some sew, I tell them that you have to go here to do this, so make it more easy for them. Because for me it was very hard, so I try to get them involved in, in community centres, how to fill them in...I (also) know a place for family, family place too, that you just can go there to have a cup of coffee and your kids play in there and you're talking with the other mums so things that kids do and some crafts and everything to have that little break from your kids too.
>
> res - especially if you don't have a lot of space at home or to get out to just have a place to go for a change? (23, interview 1, Canada).

In her comments above this woman refers to programmes run at the local community centre and the resources of the local 'Family Place', a neighbourhood drop in centre for parents and their children. At other points in the interview she talked about how she used community programmes as resources for both meeting people and for learning English. Additionally, she observed that now it is difficult to meet parents of the children her children attend school with because she, and they, are usually at work whereas, previously, when the children were younger there were more mothers around to meet and interact with, because they were not working. She indicated that many families in her neighbourhood were receiving welfare benefits. As such the opportunities or contexts within which families can interact changes with developmental stage. Families with children in the teen years found it more difficult to get to know their teen's peer group and to find opportunities to meet their families. As a consequence, parents faced considerable uncertainty about how to respond to teens' requests to spend time out with friends. The source of this uncertainty was related to parents' worries about the kinds of 'kids' their children were spending time with. These worries will be examined more fully in the next chapter.

Neighbourhoods: Seeking Safety and Affordability

Unless participants had family living in the city or country to which they immigrated their initial connections with others were largely neighbourhood based. How then did they make decisions about neighbourhood and what influenced these decisions?

A central concern for families was to locate housing they could afford in a neighbourhood they deemed to be 'good for the family'. While Britain offered the possibility of housing support for eligible families, the choice of neighbourhood to which they could move was generally a choice made by someone else. Concerns about housing had less to do with the physical amenities of the space and more to do with the social climate and accessibility of resources within the neighbourhood. Safety was a frequently cited issue of concern for families in Britain and in one instance in Canada. As one participant noted:

> "We have no chance to choose the sector or the neighbourhood where we want to live, we, um petitioned to council and about possibilities to move because...this neighbourhood is not as good as we thought it was...For the family and because we are having some problems since we moved, one of them is, um, problems with children. They can't go freely to play outside because they are in danger. There is a group of youth, teenagers... always in trouble...and bothering the children" (04, Britain, p. 10).

This mother goes on to describe problems of bullying faced by the younger children and of break-ins experienced by the family.

The neighbourhood for another family was a daily source of threat and stress that both underscored their sense of marginality and made the transition to the new country particularly difficult. This family, which at the time of migration was a couple with 4 children, was required to move from one neighbourhood to another.

> "To a house, she didn't have a choice, they said if she doesn't accept the house, she could be moving to a bed and breakfast which was difficult for her because you know, bed and breakfast they don't, we don't really have much access to the kitchen, she would not be able to cook...She accept the house but what happen is, she said on both sides where she was living, there were people from...and she said it was quite racist. She came to the point she could not let the children go to play to the playground...After three days she was living there the neighbour, they cut completely the pipes for warm water, so she couldn't have warm water...three times she's been robbed...and...one night my husband was coming from work and a few people just beat him up so badly that he had to go to the hospital...Despite all

of the complaining she did to the police, she never felt any help" (00, group Britain, interpreter & woman speaking, p. 4-6).

At the time of enrollment in the study this family had successfully petitioned the Council and had moved. In speaking the woman notes the features of the new neighbourhood that were viewed as positive. The move was to a:

"better house, still in the same area, but she's also benefiting to have a GP near to where she lives, she says also the college for her children is near and the one very very important aspect she should mention is the house is very secure, she feels safer and the children are also, they feel safer" (00, group, Britain, interpreter speaking).

This family felt on the margins of the community and the negative experiences within the neighbourhood both created uncertainty about the nature of the new community and magnified their sense of isolation and vulnerability. The actions undertaken by neighbours to intimidate them were described as racist. This example, illustrates the ways in which the informal community relationships, which were in this case negative, could be magnified by the response of the formal sector to requests for help. They found the police unsympathetic to their plight. When robbed the woman noted that the police didn't even take an inventory of what was stolen, because it wasn't particularly valuable, and after the second time the police didn't even visit the house. After her husband was beaten she began to feel they weren't important enough to be concerned about. The housing authorities too were initially deemed to be unsympathetic. It was only later that this family learned that they had been caught in a conflict between other tenants and the department of housing.

Many of the participants, particularly in Britain, explained incidents with elements of bullying or violence, like the ones referred to above, using the language of racism. Such instances occurred in the neighbourhood but also in some of the schools. For example, one family moved first to a neighbourhood where there was a younger cousin. As the mother recounted:

Mother - So they don't have much con, um, much company in that way but, um, they, they found some friends, good friends and they were very, very nice at the beginning.

res - um

Mother - and the first time.

Teen - My friends, they started being racist and throwing stones.

The mother and daughter recounted that the first place they lived things had gone well but they had to move after 6 months. The daughter who was ten at the time had to change schools.

> Teen - Yeah, we moved, I moved schools as well.
>
> res - and so then you started to have some trouble with other kids? They were making fun of you, or, how difficult was it?
>
> Teen - I didn't have enough English at that point.

The mother then recounted, another incident.

> Mother - What happened with the children around, they used to spit on you after you, you play, they used to throw stones to you, don't you remember that?
>
> Teen - Yes (05, interview 1, Britain, p. 2-3).

The teen's explanation for being singled out, was in part because she had limited English. This experience of being different and without some of the skills needed to establish connections or friendships with others, contributed to this teen's sense of ongoing vulnerability in the general neighbourhood. This teen had wanted to get a paper route as a way to make some money, the mother would not give her permission for she thought that her daughter wasn't safe in the neighbourhood (05, interview 1, Britain).

Another participant described a similar experience at school. In our interview the mother recounted an incident where she had learned her daughter was missing school. The daughter described the events that had led up to her school absence.

> Teen - Actually, I did get bullied, yeah, I got into a fight with this girl and another one said that – she told me to go back to my country. I was really small at the time, I was only 13 and then I attacked the girl and I was excluded (by the teacher). Some people in class understood – like Black people understood - like nothing is right … I did it because she did the racist thing (02, Britain, interview 1, p. 47).

Afterwards the teen said she was threatened by other students and was afraid to attend school. Following this the mother approached the school and found the teacher to be receptive to working out a solution. In this account the teen shares her view that the class was divided along lines of colour 'Black people understood'. It also points to the ways participants were reminded 'go back to my (your) country' that that they are not seen as British.

Neighbourhoods were seen as both offering a number of possibilities for connecting with others and for developing skills. At the same time, neighbourhoods, or groups of people

living in them in a number of situations particularly in London, but in one instance in Vancouver, were viewed as posing a threat. Threats were in some instances actualized through bullying, assault, theft etc. In other situations the threat was the possibility of introducing the teen to a lifestyle that undermined (or expressly challenged) the family's goals and expectations for the teen. Such goals and expectations were embodied in families' perspectives on family life. They were largely defined, or shaped. by cultural traditions and viewpoints, and manifest as *habitus*. In at least three cases parents and / or teens indicated activities with peers contributed to teens having academic difficulties. In addition a number of teen participants in Britain talked about friends, who were also immigrants, becoming pregnant. In another two instances the parents worried that the teen was taking unnecessary risks and distancing herself from the family. As noted earlier some families sought to limit teens' access to negative influences by changing schools, moving neighbourhoods, or discouraging them from taking particular part time jobs. Additionally, many parents sought to enhance teens' involvement in activities deemed positive and compatible with family views.

Although neighbourhoods were, in some instances, sources of threat they were also the contexts in which relationships were built or many resources for settlement were found. The preceding sections provided a number of examples of ways participants became involved in their new communities either by mobilizing resources for newcomers like themselves, or by participating in programmes for themselves or others. Many of these groups or organizations relied solely on resources of the informal sector. They provided opportunities for the participants, and others who had similar interests or who were facing similar situations, to meet people and gather information that enabled them to problem solve or gain access to other resources within the formal or informal sectors. The nature of these relationships is described in the following sections.

Connecting through Community Organizations

Initiating or developing connections with voluntary organizations was, for a number of the mothers, part of a deliberate strategy to ensure the children spent time with families who were both involved with their children but also working to support activities deemed to be pro-social. One woman's teenaged daughter described such activities for her included volunteering to work on community projects for the disadvantaged. I thought this latter particularly interesting for, if this family was appraised on its income and living conditions, they would be viewed as 'disadvantaged'. Yet, this teen drew upon other criteria to determine who was disadvantaged.

Teen - Every Saturday morning, like they, like all these kids from low income families come in and, you know, I get, they're the kind of kids that aren't raised in a good home, you know like kids like when you see them they're (pause)

res - They're not very well cared for?

Teen - Yeay, they're not well cared for and just like you can tell, like the way they live by the way they act and, you know, because some of them can be violent and mean sometimes so, yeah, um, I went there really almost a year, I think. But it was only like on Saturday mornings and I'd kind of just like, just give them food or kind of play with them…

res - so, looking at that how did that make you think about how you would organize your life? What you're thankful for in your life?

Teen - Well I guess I'm thankful, I mean my parents, you know, to actually give us a good education and everything else not like, you know, other people, or other kids that I've seen that it's kind of obvious that they don't have, they don't get the attention that they need, right? (23, interview 2, Canada, pp. 8-9).

The teen speaking above defines advantage in terms of qualities of family life and not solely material goods. She recognizes as well the investment her parents have made through the way they have cared for her. This family's home, which was in a low income housing project, and as such was as modest as others visited, conveyed a sense of organized family life. There was a flower and vegetable garden outside of the door, which unlike most of the neighbouring flats, had received attention. Family photos were in collages and frames about the entrance hall and in the kitchen. The space was tidy and welcoming although space was clearly at a premium. For example, while I interviewed the teenager in the kitchen, the father slept on the couch in the living room and children played upstairs in the bedroom (23, field notes, Canada).

Another teen indicated her mother had volunteered her to help in a voluntary organization where she used her ability to speak both Spanish and English as a volunteer interpreter. Still another teen had been encouraged to participate in the church youth services. While at the time of my first interview with this teen she was somewhat disinterested in this involvement by the time of the second interview she had taken on more responsibility, organized a youth led service and received recognition from the pastor. In this latter instance the church was also a source of criticism for this teen. As both she and her mother recounted it, there were people in the church community who had spoken negatively

about the teen. The impact of these comments seemed to have been mitigated somewhat by the formal support and recognition by those in a leadership role in the church.

One mother who was committed to fast tracking her family's adaptation to their new community took full advantage of community resources available to her for free or limited cost. I asked her what was most helpful to her in getting settled.

Mother - I think it, um, it depends a lot on myself.

res - You took the initiative?

Mother - Yes

res - You went out and -

Mother - Probably a lot, well, I went for, I think it's a necessity and I

res - Yes,

Mother - And so to go to, to be involved in many things.

res - um, Like what kinds of things?

Mother - Um, the boys of my children are in this Scout group.

res - in Scouts uh huh

Mother - We go to church.

res - uh, hm

Mother - Uh, nobody speak Spanish there, but we learn the English and I really am..(pause, looking for word)

res - emphasized that?

Mother - Yes. So we, it was, if we are living in an English country, we have to learn. That way they learn very quickly. I did, I know for them to, to learn as quick as possible.

res - uh hm

Mother - Like buying videos, getting involved in many things, going to the library, going to the swimming pool, I don't know, many things, and also going to the Youth Club as well.

res - Youth club?

Mother - uh hm

res - Is that a community club or?

Mother - Yes, yes and

res - You liked that? (to daughter)

Teen - yeah

res - What kinds of things do you do?

Teen - um, we play pool, we have like a little meeting with Sisters (of a religious order) and

Younger child - and we have swimming

res - Oh, it's partly through the church or through the school?

Teen - No, from my school.

res - So, you're at Catholic school?

Teen - Yeah,

Younger child - The Youth Club is like, it's great.

After this discussion with the teen about ways she was involved in community activities, the interview was redirected to elicit more of the mother's perspective on this.

res - It must have been hard work but you felt that was the most important thing to do?

Mother - Yeah, It think it's very important to involve them or you don't, you're not, well, I mean I'm no English, I will never be English but I have to, to know their customs, their -

res - right, right

Mother - Otherwise you are out of the world, out of the,

res - picture? (05, Britain, p. 3-4)

It becomes clear that this mother recognized the value of knowing how to 'get along' how to fit in this new society. She sought to acquire, and have her children acquire, what Bourdieu would call the 'dispositions' that would help them to get along in the context of British society. She drew upon the resources available in the community to accomplish this. This mother's goal was that her children develop English language skills, and that they become involved in pro-social activities in the community.

English was a second, acquired language, for the participants in this study. Some had immigrated with some degree of fluency in English but the majority had learned English, either through government sponsored programs, or community based programs and/or by seeking out opportunities to practice speaking with others. Such activities also provided opportunities to learn about the resources of the community and to develop friendships.

Teens were clear that English was key to getting along, to participating in school and to making friends. One teen in Canada indicated her older sister who had learned English was a real help. She acted as the family link between the teen and school. The ESL (English as Second Language) classes at school were also helpful. At the time of our interview this teen had moved from high school, where many classmates were also immigrants, to college where the numbers of immigrants are fewer. She found this transition difficult.

> Teen- It's more difficult to have real friends because now in college most of my friends are speaking English and they are English people. Not Chinese...Some of them still have some racism. I can see that even in the teachers - the instructors (44, Canada, interview 1, joint, p.5).

I thought this teen had an excellent command of English, nonetheless she says differences stand in the way of making "real" friends.

While some participants clearly made learning English a priority, others observed that from their experience many immigrants view learning English as a choice they often cannot afford.

> Mother - They're always trying to keep, to get money and work really hard just for money...I used to tell my friends, you should study English...and they said, 'Well what would I learn in one day?' For instance, or 'No, I have to work a day, that hour'. Even if they say it's very, very low (pay) they prefer to work (05, Britain, joint interview 1, pg. 9).

So, for some immigrants the desire to be financially secure was weighed against taking time away from work to learn English.

A number of participants indicated that one of their reasons for participating in this study was because they saw it as an opportunity to acquire information about the University and about nursing programmes. Some were gathering information so they could offer guidance to their children. Several of the home interviews had segments that I would characterize as discussions. For example, one woman shared work-related experiences in Britain and in her country of origin. She then asked me about some of the premises of the study I was undertaking as a means of exploring possible areas of common interest. This participant was exploring ways of fostering community-based initiatives for ethnic minorities in London.

Language and other Social Markers

As the preceding accounts suggest learning the language of the new country was not simply about language skills. While some teens readily picked up English, other instances in the teens' accounts suggest that the emphasis on learning English distanced them from their countries of origin by making it difficult to maintain connections with others. Additionally however, as recounted earlier, one teen was bullied and picked on by peers because, in her view, she stood out as different because her English was poor. Another teen indicated that speaking with an accent or speaking her first language made her stand out as different - even though this language was offered as an elective at her high school.

res - So I assume (because I could hear her mother speaking Spanish to her siblings while I interviewed her) you can, you've kept up your Spanish, have you?

Teen - um, not really because my mum wanted to learn more English and she told me to start speaking English, then so I did and then I sort of forgot most of it and it's like I know some words, I just don't really know what they mean.

res - um,

Teen - and then my dad talks English to me and my brother and my sister both speak English to me too. And then, there's like some of my friends speak Spanish to me but then they're from, um, different countries so like their Spanish like one word may mean something else from what I know (21, interview 1, Canada, p.7).

The mother in this case presents another perspective on the daughter's disinclination to maintain her first language.

Mother - She doesn't want to speak our language. She understands but she doesn't, when she was five years, she got worse and my son he start to laugh, you know, he says, ' Oh, you are not good in Spanish'. From that time she say 'No, I don't want to talk in Spanish'. That's what I think. And so now, she wants to try to speak but it's more difficult for her...and she gets stuck now, she wants to communicate with my family and she can't so it's difficult time for me....

Later the mother commented that when there were opportunities to interact with others in the community the daughter would say to her

...'I can't speak in Spanish, they will laugh at me because I can't speak'. (21, interview 2, Canada, p. 9).

While language is necessary for establishing connections there is also a link between language and the teen's own sense of who she is, or how she wants to present herself to, and be appraised by, others. These concerns are echoed by other teens in the study.

Teen - I think we mix the two cultures in a way...when I'm with Columbian people, I have to act like them and when I'm with English people, I have to try to think like them in a way (01, Britain, int. 1, p.17).

Language can be seen to be a key component of *habitus* as mothers and teens recount "you have to know the customs" but also the loss of the first language can make it difficult to

mobilize *habitus* and maintain connections with the cultural community. By contrast some teens immersed themselves in the language and activities of the broader community.

> Mother - He only speaks English and also his friends they only speak English.
>
> res - So he's choosing friends other than Chinese background friends?
>
> Mother - Yeah, maybe it is same background and you could see it, he's just like Canadian boy, he has no idea about Hong Kong.
>
> res - How do you feel about that?
>
> Mother - I think it's just up to him, because he likes hockey very much…I think Chinese people, um, they prefer their children to know some Chinese, um, to do both (30, Canada, group int. p. 17 – 18).

Those who were able to speak the language of their country of origin noted it facilitated the establishment of connections with others. However, placing an emphasis on establishing and maintaining connections with others who spoke the same language could hinder efforts at establishing connections with others outside of the community. Such hindrances are understandable when English language skills were limited. But in a number of cases language was also a marker that made participants feel visibly different.

Teens and parents both spoke of the negative impact of being categorized as immigrants or refugees. For two teens choosing their friendship group from among others within the language community was viewed by parents as problematic because it effectively restricted their access to the broader community and the opportunities associated with it. A third teen in Canada had chosen to spend time at school almost exclusively with other teens of similar heritage. As a consequence, his mother, who actively sought out opportunities to interact with others in the community, in part to develop her English language skills, seemed more fluent in her spoken English than her son. The teen indicated that although he had classmates who were 'Canadian' his friendships were with teens who spoke Cantonese.

Reconciling past with present and straddling different *habitus* within the family context was an ongoing issue for many families. As noted above, maintaining language competency enabled parents and teens to access their history and maintain connection with relatives. In the following account a mother describes some of the ways the new - transformed - *habitus* contradicts the traditional *habitus* and how she has sought, with time, to reconcile it and become 'modern' but in doing so to also anticipate the potential negative health outcomes.

> Mother - I'm still very much in my mind although I'm very open and modern but somehow in the back of my mind you still think, oh God, you know, we

have to be virgin, we have to, kind of like behave in a certain way but your, your mind is still working that way but then your knowledge and feelings and manners and all that has changed slowly throughout the years, uh, so I think the best for the moment is to, you know, tell my daughters, you know, just to be, um more, not 'conservative', but, um,

res - be sensible?

Mother - sensible, yes, that's the word

res - em,

Mother - that is the word, yes, use good judgement. If they choose to go with a different route then they have to be sensible, you can't, tell them the way we wish or the way we were brought up anymore (10 group, 12, Britain).

This same woman however, notes that she continually struggles to maintain connections with her own cultural roots, her personal history, and the structure of relationships within the family context. As she speaks we can see that part of the struggle is that 'intellectually' (or for a person educated in the west) it doesn't seem to make sense to maintain ties with this personal history and the traditions associated with it.

Woman- But in my own, I mean I, I'm the one who very much struggling because, um, although I was born and raised and lived in Vietnam for many years before I left Vietnam you, know my foundation is still our culture. And I, but I live in the west quite a long time, um I would like to think that I'm educated therefore I read a lot and I'm doing you know, lots of - a few degrees - so for that sort of thing my mind, we're struggling between the two cultures, although logically we think, em, some of our culture was a bit rigid and this and that but,

res - but emotionally

Woman - yes...so, you know, that's what we feel comfortable with, you know, I'm like, I said I'm forty-six years old now and I, when I go home now to my mother … I wouldn't answer back, you know or I would say to her I'm going now, I'm going to be back at 8 o'clock… but my children didn't perhaps, doesn't see it that way...We cannot, uh, have the control to live their life like you used to live with your parents even though you wish to do so with your daughter...we change …even so we still keep some cultural background (10 group, 12, Britain).

Participants' Views of Health

The preceding accounts introduce the participants' migration experiences. The literature reviewed in Chapters 1 and 2 suggest that persons like the women who participated in this study are more vulnerable to health inequalities. The migration stories introduce a number of issues that can be seen as having a potential impact upon health, such as limited networks of support, living with the stresses of poverty and teens feeling they face an uncertain future in their new countries.

In what follows I introduce the study participants' perspectives on health and health services. That is, here I introduce the comments made that specifically refer to conventional views of health.

In the group and individual interviews I asked participants about access to health services and in individual interviews I asked about the health of family members while exploring the nature of formal and informal resources drawn upon to manage identified issues. In discussing the latter I asked what contribution, if any, the participants thought they or the broader (ethnocultural, developmental or geographic) community could make in the design or delivery of health resources.

Access to Health Services & Nature of Health Status

In discussing access to, and use of, health services, one mother indicated they accessed the services of the GP particularly for infections "bacteria problems" but, like others, might also use the services of an acupuncturist for help with rheumatism or other non-acute conditions. All participants indicated they were familiar with, and used, the services of practitioners of western medicine. With the exception of those who had received new baby visits in the post-partum period, the point of entry to the system for illness care was in all cases the general practitioner.

A number of the participants, or a family member, had an ongoing health condition or had been a victim of violence (i.e. beating, rape) and were dealing with the effects of these attacks which in the case of one teen involved an extended hospitalization for depression. Other health issues discussed were episodes of acute illness or concerns about health promotion. Parents in particular worried about their daughters' sexuality with some also mentioning concerns about preventing smoking and drug and alcohol use. Further, managing health and illness within the family was generally viewed as gendered, that is, within the mothers' domain of responsibility.

Mother – yeah, well, maybe Canadian people will get involved in that (managing health) but with Spanish women, (laughs) it's a woman's job. (23, Canada, int.1, p. 25).

Like others, this woman has not had difficulty accessing illness care through the services of a GP. She has had the same Spanish speaking physician since her arrival in Canada. She has also used other resources like the Family Place (a community resource for young families), attended parenting classes led by a Spanish speaking community health nurse and has drawn upon other community based resources for immigrants.

A number of participants spoke of the need for more health promotion programmes. In particular, information about prevention of what they viewed as 'illnesses of the west'. One mother who sees herself as a health conscious individual spoke about a shift in awareness about health subsequent to migration.

Mother – It's different from where we were in Vietnam which is where I grew up. Nobody talk to you about health issues, you don't see it you don't hear it, the government, you know, everybody is busy with the war so nobody mention health issue. That is the last thing on their mind.

res – Right.

Mother – But when I came to the west, um, health issue is quite, play an important part in our life…because of problems we haven't seen before, like cancer (12, Britain, int. 2,p. 2-3).

Another participant made similar observations.

Mother – The Vietnamese community is quite a young community, only about twenty years old, but recently there is a lot of problem, health problem, the Vietnamese suffering the same health problem as their host country.

res – Oh, like?

Mother – Like blood pressure, uh, coronary artery disease, diabetes and cancer.

res – Which weren't very common in Vietnam?

Mother – It's not very common…(but) here quite a lot of people die of cancer and they are quite young as well, they get younger and younger particularly women…The elderly people in Vietnam they used to die of old age, but in here you see a lot of people suffering from diabetes, high blood pressure. (11, Britain, int. 1, p. 15-6).

Parents, and in some instances, teens, indicated health behaviours, and efforts to reduce exposure to risk, had been influenced by what they saw as practices of the broader

community. Some examples of this were raised in earlier chapters where parents spoke of a dislike of what they saw to be a general permissiveness of the broader society. For example, in commenting upon her daughters' health practices and how they are managed one mother observed her first daughter was a model child.

> Mother – (However), my second one (daughter) she's not that sensible and she smoke and, you know, not drinking as alchoholic but, you know, - drinking (12, Britain, int. 2, p. 6).

This mother then went on to discuss her view that these practices were prevalent in the broader community and she thought of them as health issues for youth of the west, which now included her daughter.

Other mothers discussed what might be broadly viewed as mental health issues that were tied to their status within their new country. Mothers observed that their daughters faced particular challenges and expressed concern about how to help them navigate two cultures.

> Mother – You know in this country education play a very important role apart from your family. Eight hour a day you spend in school so education play a very big role in the life of the children.
>
> res – in socializing?
>
> Mother – you know, so I think that, uh, my daughter even so she doesn't have identity problems, but she still very aware of her own identity (11, Britain, int. 1, p. 9).

Other differences between countries of origin and their new countries were observed to have an impact on health practices. As one mother noted "Life in this country is more comfortable" in part she observed, "because of the welfare support system, which means you don't need your children to support you". But later she noted as a consequence "mental support" is lacking because the family and community network of support between generations has not been sustained (11, Britain, int.1, p. 17). Nor, it seems, has this network been replaced. This woman also observed that housing design was another factor that contributed to this situation, as housing does not accommodate intergenerational households.

A number of others spoke of the importance of supportive relationships, both within the family and through connections established outside of the family in the community. For example, one woman indicated that overall she felt well off because she has a husband and children and is therefore, not alone. She contrasts this with the experience of a friend who became separated following immigration and whose daughter subsequently left home. This friend became suicidal. Another woman contrasted her experience with that of others':

> Mother – I have found (by reading the Chinese newspaper) some have got mentally depressed but if they find a job, they get the money, so, um, I suggest many people they have those problems. They need to find, to help them to have a job, no matter if it's a wealthier job or something, they can use, find their spirits, expand their spirits" (45, Canada, int. 1, p. 39).

These women's comments merit further examination for a number of reasons. First, the observations about illness profiles are supported by studies in both Britain and Canada that have shown a decline in health status over time following migration. But also, while these women, like others, live in very limited material circumstances it is the change in social network, the support derived from it and the opportunity to contribute to the social network that is viewed as having an important effect.

In the discussions about health services the participants' experiences were primarily with community based medical services generally accessed through general practitioners. The participants' comments suggest that such services were generally viewed as accessible.

In one case a participant discussed hospital care and commented that she thought she had received excellent medical care. However, the hospitalization experience was quite stressful for the family because of difficulties in accessing information about the illness and treatments in Spanish and her own difficulties in making her needs (illness related pain, discomfort, worries) known to the care providers while in hospital in London. The data however, draw attention to a number of issues related to access and how they were handled, many of which were related to language.

In a second case a teen was hospitalized for treatment of depression following rape. At the time of our interview the teen did not go into detail about this experience and her mother didn't encourage it because she thought the teen was still quite vulnerable. The teen did however indicate that her main concern at the time of interview was that as a consequence of this hospitalization (its length and timing) she had lost her academic year and had therefore been placed with younger students. As well as making her feel as if she had failed she also indicated this change meant her friends had moved on to the next level and she had difficulty staying in contact with them and, as a consequence, felt particularly alone.

In Canada, many of the participants indicated they had had the same practitioner for many years despite having moved a number of times because there are no geographical constraints on Canadian GP's practices. Participants also indicated they had selected a practitioner in part because he or she spoke their first language. In Canada, there are no formal provisions for interpreter services within general medical offices so if the physician did not speak the language of the participant it would be up to the patient to arrange for

interpreter services. Vancouver did have a clinic that offered a range of illness care and diagnostic services in a number of languages which one participant had used.

In Vancouver, prevention (health promotion) programmes, were staffed by practitioners who spoke different languages. Also, interpreter services were available for home or clinic visits associated with prevention programmes and all health promotion educational print materials were available in a number of languages.

In London, patients were eligible for interpreter services although all were not aware of this. Some had learned about this provision after contacting a voluntary organization, while others had learned about this from settlement services.

Although there are a variety of youth clinics available in Vancouver and nurses are available in schools in both Vancouver and London none of the teens, in London or Vancouver, indicated an awareness of these. If they used medical services they were accessed through their GP. For the most part teens indicated they at times made their own appointments while at other times appointments were made by their mother.

Roles for Community Organizations in Health

In response to my questions about community involvement in health programme or resource development overall I had the impression that participants saw health programmes as the domain of the health professionals. However, in several cases, key informants and women participants who had a background in health either as practitioners, or because they had received education in their own country, commented on ways health professionals could benefit from partnership with communities. The responses reflected a view of health and approaches to fostering health that extended beyond traditional definitions.

For example, one woman in London spoke at length about what she viewed as a 'missed opportunity' for input. This participant recounted a situation where she, as someone who was familiar with the experience of migration and who had formal education as a health professional, was asked by a voluntary organization to attend a workshop being held by the area mental health team. The workshop was, from this woman's understanding, to have focussed on issues related to the provision of mental health services for immigrants and refugees. By the study participant's account however, the workshop leaders did not provide an opportunity for the workshop participants, who included immigrants and refugees from a number of different countries involved in the work of different voluntary organizations, to offer their views on needed services or on approaches that might enhance accessibility or efficacy of programmes. Rather, the health professionals used the workshop to present

biomedical definitions of mental illness (depression and psychosis, etc.), to describe symptoms of such illnesses and to outline treatments available.

The woman who attended the workshop commented that she and the other workshop participants were being told what mental illness was. The workshop presenters were not receptive to alternative views of such symptomatology, nor did they appear to be interested in hearing about alternative approaches to treatment. But what was perhaps of greater concern to this woman was the lack of attention to, or consideration of, conditions faced by immigrants and refugees that she thought were the root causes of particular mental illnesses such as depression, within this population. And, the lack of discussion of types of initiatives that could be undertaken to foster mental health among immigrants and refugees. In effect she commented that, contrary to her expectations, the workshop did not provide a forum for dialogue on views of mental illness. Rather, it was an activity designed to 'make immigrants and refugees fit into' the professionally defined viewpoint. The woman I interviewed therefore felt that what could have been an important opportunity for mutual education towards a better understanding of mental health or mental illness was lost (Britain, field notes, May 2001).

One participant said in her response to my questions about community roles in health; "What you are talking about is empowerment. It is necessary to build community and to empower the people within communities". She went on to say that in her view illness care was not sufficient, that a broader approach was needed. This woman then described how she had been involved in community building among women in villages in her home country. This initiative had led to the development of a community based health organization. Although this woman had considerable expertise, she was not able to work in her profession. However, she actively explored ways to offer input into the formal health care system in Britain.

Participants described the ways voluntary organizations could facilitate individuals' access to formal health care. Such organizations, in their view, recognized that newcomers often had different help seeking practices. Voluntary organizations had roles to play in enabling people to gain access to health care by recognizing and working to overcome barriers identified above.

> Woman - ....but there is a problem for the women who have language difficulty. Because if they have language command they can access the information and services by themselves, they don't need us.
>
> res - Right,

Woman - they don't need anybody, they just go and access it by themselves. But, if they've got that kind of problem (with the language) they are not very confident to go out and seek information.

res - So language is an issue?

Woman - Very, very important because if you don't know the language you are not willing to go anywhere to seek advice because it seems that if you don't know language you are easily put off, so I think language is a key issue.

res - Yes.

Woman - It gives you confidence, when you can speak your language you are confident to go anywhere. You can go to the doctor and you can argue with him and you can put demands forward as well. But when you don't have the language command, you are not 'even' (meaning not in a position) to argue with him or to ask for something. One lady said that she only knows her GP but I said, 'that's to cure, not to prevent'. She doesn't know any others about preventative sorts of, you know, and it happened to lots of people because I mean although we are sent information through here (meaning organization) and then of course, sometimes we can translate it and put out things like (pap) smears tests and that sort of thing, breast cancer (screening), but it's not like there is a lot. We can't do it all. So we need, you know, I think what the community needs is health promotion. Much more work. Much more proactive, you know...and I think we need professionals, that's why sometimes we organize, um, we call 'health promotion day' and a professional would come in and talk and then we translate to a group of people. But we need more of that...

res - So do you find that you initiate it or they (health professionals) do?

Woman - We initiate that

2nd Woman - because we work with them (community members) on a daily basis.

Woman - so we know what the needs are and when there is a potential problem. For example, there is a lot of cases about breast cancer or about menopause, so we will organize... But when you (meaning health professionals) send out information, a leaflet...they throw it out. But when you talk with them face to face you get more response.

res - I'm thinking as well is there, for example, a health visitor or a public health nurse that could meet with that centre?

Woman - um

2nd Woman - We are a community centre, we are not a health centre (some discussion ensued)... The problem is here, the health visitors and nurses, they attached to GP and if they are GP fundholder, then they have a set money to do it (health promotion). If I invite one health visitor and she worked for that GP then it is that GP. They say, 'Oh we don't do it for other people's (people outside of the GP practise) benefit'. You know, and that sort of, because there's so many GP's around and in one area like this...so we need from Health Authority, people from Health Authority, health promotion (Group 10, Britain, sections pp. 20-25).

In the discussions that ensued the group participants gave examples of initiatives within the formal health care system (e.g. vision screening) that had successfully accessed community members through the organization.

These participants' comments reveal the varied forms of capital available within the voluntary organization. Expertise included knowledge of help seeking practices, familiarity with peoples' health concerns or needs for health information, knowledge of participants' first languages as well as knowledge of changing patterns of illness within the population.

The participants' accounts suggest people have different understandings of the ways in which health services are organized and delivered in the British context. As noted above, for many, this lack of understanding acts as a barrier. The women also observe that approaches to health promotion and health education that are used for the broader population may be more limited in their effectiveness with their community if print materials are the principal means of conveying information. The participants suggest a variety of ways that health education initiatives in the community context would be enhanced by outreach programmes that capitalize upon partnership with community based organizations such as their own. In these examples, voluntary organizations facilitated access to health care and other organizations, particularly in the formal sector, by overcoming barriers or through advocacy efforts.

A number of other study participants spoke of ways they engaged with organizations to address issues of concern to them. A number of these undertakings differ from those described so far in that many of them represent collective efforts. That is, participants either initiated or joined with others in a shared purpose. Furthermore, the most frequently mentioned goal for such initiatives was to create a resource to fill a gap in service or to meet a need that was largely overlooked by existing structures. As such, these initiatives became community building initiatives.

But also the initiatives, because they brought together people and because they invited people to contribute by drawing upon capital, became a forum of community support and affirmation. Finally, as the accounts that follow can attest, community based initiatives offered others an opportunity to develop skills, hence they contributed to capacity building.

A number of study participants, particularly mothers, knew how to draw upon their knowledge of social and community organizations in order to draw attention to, and in some instances address issues they, their families or others in the community were facing. While many initiatives began as grassroots initiatives within the informal sector, the data provide a number of examples where participants, or others, mobilised a group around a common issue and subsequently engaged with, and in some instances mobilized support from, the formal system. These processes are examined because the participants' accounts illustrate a reciprocal process of capacity building that accrued from community building initiatives.

Fields of particular interest to mothers included those that facilitated settlement subsequent to migration, those that were related to their work or career and those related to their roles as parents. In addition, many of the participants had established connections with different faith communities.

While teens clearly needed to develop competencies, or capital, and have this be recognized many of the mothers had extensive capital, although it was frequently unrecognized. Mothers' encounters within the community in some instances offered opportunities to use and further develop their capital in community building initiatives.

One woman drew upon the professional work-related knowledge and skills acquired in her home country to join others in volunteer work in a voluntary organization in London. She says the work she does has helped her to develop a social network which was sharply diminished upon migration. But as recounted in the group, it is:

> "like a way to deal with a situation...it gives her purpose and a place to contribute...she feels she is doing a good job because of the things she has been in herself...and she knows how to, to do, to help manage to help other people...People say, look at (woman), and put her as an example to go out and, fight the problem and confront the problems we did and fears, you know" (group 01, woman, 04, Britain, p. 13, translator speaking).

As this woman recounted her story she illustrates how she drew upon her professional credentials and work experience as she worked as a volunteer with the community. She also drew on personal knowledge of the fears and challenges people are facing as newcomers and

difficulties people face when coping with illness of a family member. Such initiatives can be seen as accruing 'profit' for this woman in that she received considerable recognition from others in her language community and felt a sense of personal value for having made a difference. However, she was not being paid and money would have made a difference to the family. Many of the people who did volunteer in community organizations did so to acquire experiences to facilitate their search for paid employment (field notes, sites 1, 2, 3, Britain & Canada).

Another example of this was provided by one woman who, following her immigration to Britain found herself in a small community without resources for immigrants decided to try to create opportunities for people to gather together.

As a result we:

> "started to organize for like New Year's celebration and that sort of, you know, day center... Well not a day center, a lunch club for older people but um,
>
> res- But through people you meet other people.
>
> Woman - Yes, yes (group 10, woman 12, Britain).

A third woman used voluntary activities as a means for becoming a part of the broader community.

> Mother - I came from Hong Kong six years ago, with only four of us, my husband (and my children) and so no other
>
> res - extended family?
>
> Mother - Right, so I feel a little bit lonely, uh, however I have some, um, my family friends
>
> res - uh hm
>
> Mother - are there and they help us for some sort of things so it's very lucky and during this six year I participate in, um, doing a volunteer job and I get many friends. So nowadays I feel very happy....
>
> Group all talking and laughing. (40, group int., woman 45, Canada, p. 6).

Recognizing a need and taking the initiative to mobilize others to address it, was an approach that many of the study participants spoke of. In a few situations the initiatives resulted in the development of an ongoing voluntary organization that created possibilities for people to become involved and to expand fields of connection with the broader community. Such initiatives also provided opportunities to make contributions to the community based upon capital (forms of knowledge and experience) that is largely unrecognized in other forums. But perhaps more importantly such collective efforts opened

new doors for participants. In addition it is evident that different forms of capital are viewed as holding value and new forums of affirmation developed because initiatives were undertaken with others.

One woman described how activities she was involved in to support newcomers developed into a funded voluntary organization. She recalled that there had been a field worker assigned to them to assist with resettlement when they were first in the reception centre. This person took the initiative to set up an organization to bring refugees together. She and others involved saw the same need in different areas of the city and so began informally helping people to connect with one another.

> Woman - So that's how we come about forming this (organization).
>
> res - So doing what you were doing informally?
>
> Woman - yeah,
>
> res -You were able to organize into a more, um,
>
> Woman -yeah, like a formal
>
> res; like a formal structure?
>
> Woman - At first, and then it's expanding when we got the funding from the local authority but in the first place it's, um, usually the people who, who start forming the organization is the one who was the reception officer in the first place, yeah.
>
> res - because they know everyone and
>
> Woman - yeah,
>
> res - and will have some skills and some..
>
> Woman: yeah, they they are refugees themselves as well. So they got experience, the first hand experience and then this, um, the background experience and their experience of the refugee themselves as well.
>
> res - right
>
> Woman - So that's why they want to help people who are in the certain position, in the same circumstances (group 10, woman 13, Britain).

In these examples the capital drawn upon included formal knowledge and skills. In addition knowledge of the migration experience was recognized as a form of capital that held value within this social context. The outcome for all of these participants was a sense of affirmation or personal value and of being part of, and contributing to, something.

The next example illustrates the ways one woman drew upon her knowledge of formal systems to effect change. She capitalized upon mechanisms in place to convey community input in the formal decision making structures. This woman who, like other

parents, highly valued education, was of the view that the educational approach within the local Canadian context did not place enough emphasis on the acquisition of specific forms of knowledge and, among other things, accorded too much freedom to students. This latter issue, in her view, eroded students' respect for the adults. At the time I interviewed this mother she was actively engaged in mobilizing support within the parent community to make the case for the creation of a traditional school as an option within the publicly funded system. Such schools have been funded as alternative schools in other school districts. The traditional school would in her view be more in keeping with her expectations of education in her home country. What is of interest here is that rather than simply supplementing her daughters' education she chose to work within existing structures to present the community perspective of a collective of parents to the elected school board officials. In addition to mobilising individual parents in support of this initiative she approached voluntary organizations within the community that had a more general interest in education to partner with her in this initiative. One important formal structure available to her was an elected school board that held open meetings. Within this structure there were also provisions for groups or individuals to make presentations on educational issues. The board also held community consultations on specific programmes within the public system.

For this woman, the requested changes were seen as both a right within a democratic society but also a means of affording recognition of alternative views held by numbers of parents. As she undertook this initiative the woman received ongoing feedback and support from people within the community not only for her efforts in changing existing structures but also for drawing attention to different perspectives on education. She represented a perspective not reflected in existing social structures and educational policy. While all initiatives undertaken by participants did not result in the creation of programmes or organizations, many of the initiatives were characterized by reciprocity in that women purposefully sought to establish connections with others, and involve other newcomers in activities, and/or organizations. A number of these initiatives were collective efforts and contributed to a sense of community.

In this context community refers to a sense of connection with others around a common purpose. As such people may be a part of a number of communities that may intersect or be independent. It is clear that for many of these participants having connections with persons who spoke the same language created a sense of community, but persons in such groups did not necessarily have a similar heritage or social history. Religious groups also provided many with a sense of connection with others, although often they indicated there were no others who were immigrant, or who spoke their language. How to define

community has been discussed by a number of authors including Curtis and Taket (1996), McKnight and colleagues (1994) and Lynam and colleagues (2000). Curtis and Rees Jones (1998) also examine the intersections of landscapes and a sense of place as features of community. In efforts to address minority issues a number of initiatives have been developed to target 'ethnic communities'. Participants in this study would likely have been overlooked for, only three of the participants had organizational links to an ethnic community organization.

In contrast to the number of examples of mothers' active community involvement the data offer only one example of teens engaging in a collective effort. For example, one teen recounted the difficulties she and her classmates were facing at school. Recently her math teacher had changed. The new teacher was not helping them. As she described it:

> Teen - We've got our GCC's coming up in December, and she won't - well - even if we work on our GCC's she doesn't even bother explaining them. She just write them down and like, um, you see my other teacher, she left now, my other teacher like she write the work on the board and then say, anything you see here that you don't understand, we will lift the hands and she will explain to us. But now this teacher, oh gosh, she's terrible, she's terrible.
>
> res - She's not teaching?
>
> Teen - not teaching. But yesterday people complained. People in my class...they went to the head teacher and they told, we told, well actually they told him how she isn't helping - teaching...I don't know what is happening now. (02, Britain, int. 2).

In most instances the teens saw themselves as acting as individuals within (or against) different fields. While some teens had relationships with adults with whom they could consult around decisions, for most of the teens the adult resources were parents and at times the difficulties teens faced were ones that parents were not in a position to address. Also, teens were often engaged in negotiating change within the family and as such it was often difficult for teens to feel supported by their parents when they were actively engaged in challenging them. This was one instance however, that the focus of challenge was outside the family and involved a collective effort towards positive ends.

These teens take the initiative to change the situation by mobilizing support from the head teacher and, as such, they were involved in working collectively to address an issue at an organizational level. What was more likely was for teens to comment that the difficulties they faced were ones that were a '"Fact of life' in this country".

The teen recounting her efforts towards self-advocacy had been exposed to such initiatives at home. Such action was in keeping with a number of her mother's advocacy efforts. In the interviews the mother spoke of advocacy with outside organizations efforts on behalf of the family. She also however, sought to have her daughter recognize her potential and instill in her daughter a sense of self worth. This latter was accomplished in part in conversations like the one I participated in. In one conversation the mother points out some of her daughter's capabilities and shared the family history of involvement in the community as advocates. She was very aware of the rights of citizenship, both those which had been violated in their home country and those of their new home. In this way the mother created continuity between the past and their current circumstances. She advocated for the family with the housing authority, with the police, and for health and education services for her other children.

Are Concerns about Health Eclipsed by more Pressing Concerns?

These accounts suggest that, overall, participants observed that illness care was available and they were grateful for it although they did place some caveats on the ways language influenced accessibility. As noted, concerns about the availability and accessibility of health promotion and disease prevention initiatives were raised.

In speaking specifically about health the participants made a number of observations that align with broader views of health and health inequalities. These include the importance of networks of support or deriving a sense of purpose through work or community involvement. Parents were also concerned to ensure teens develop a strong sense of identity. A few participants suggested that health issues arose out of broader social conditions and the place of immigrants in society.

What is particularly striking however, is that even though this was presented as a study about health and a number of families, particularly in Britain were managing ongoing health issues, the topics of greatest concern, about which they spoke at great length, related to issues of marginalization, their sense of vulnerability in these new communities and concerns about safety. In effect, their greatest concerns were related to difficulties they faced in establishing relationships, being seen as persons of value and worries about being able to secure a future.

While mothers could be seen to be weighing difficulties they were facing (loneliness, downward mobility) against the poverty or oppression they would be facing in their home country, they expressed great concern and worry about how their teens were managing and whether the costs to their daughters were too great. In their discussions of health a number

of participants identified a role for voluntary organizations as resources for health that were seen to address issues that were not being taken up within the formal health care system.

Women's involvement in community building activities had a range of effects. In most cases it expanded the women's knowledge of the broader community's resources and traditions and provided opportunities for the women to develop new competencies while gaining the confidence that accompanied positive experiences. The mothers' positive experiences often accrued from having their viewpoints affirmed and from having enabled others to overcome some form of difficulty and from expanding and diversifying their social network.

These positive experiences stand in marked contrast to the women's experiences in the formal workplace as described earlier in this chapter. The latter were less positive because women experienced a lack of recognition of their credentials, and their roles in workplaces rarely offered a forum for recognition, or, in some instances recognition took the form of exploitation.

Being successful in advocacy efforts meant that the participants were successful in presenting their viewpoints in the appropriate forums and were able to mobilize the support, recognition or change that was needed. Participating in the development of a community based initiative also accrued benefits for those who developed the initiative and for others for whom community based organizations played a role in dissembling barriers, or in bridging viewpoints.

Reflections on Migration Stories & Views of Health

Bourdieu and Smith's perspectives can be drawn upon to guide a critical examination of these migration stories. These two theorists draw attention to the objective relations that shape and underpin social life, and prompt the analyst to make visible the ways the taken for granted social order shapes experience.

Subsequent to migration participants developed awareness of disjunctures in *habitus* that became manifest in their differential capacity to appropriate capital and social power. These were particularly evident in the participants' efforts to gain entry to work roles for which they had previous experience and/or as they realized their status as 'immigrant' or refugee contributed to their location within the workforce, within a neighbourhood, or within a school. Teens in particular spoke about their observations of the disjuncture between the family *habitus* and their experiences within the broader community. The accounts illustrate the nature of the struggle that is associated with the participants' efforts to create and maintain symbolic capital.

What these migration stories draw attention to however is that the issues being faced are viewed as part of the 'immigration package'. That is, it is to be expected that immigrants will face these types of challenges. Bourdieu however, observes that this view of the expected is what is problematic.

> "What is problematic is the fact that the established order is *not* problematic, and the question of the legitimacy of the state, and of the order it institutes, does not arise except in crisis situations" (Bourdieu, 1998, p. 56).

That is, these stories illustrate ways that the taken for granted order is taken up as an unquestioned reality with an associated legitimacy. The newcomer, with a different social history, enters with a different predisposition or set of expectations. As many of these participants' accounts suggest the time post migration was characterized by a developing awareness that despite aspirations and effort, many were constrained in their attempts to move outside of the social space assigned to immigrants.

While the mothers participating may have observed this contradiction or noted the negative consequences of not having capital of value in this new country, and they did in some cases see this as problematic, they did not 'prompt a crisis' or seek to confront such disparities at the system level. Rather, parental efforts were primarily directed at seeking to ensure their children had the necessary competencies - capital - valued in this new societal context.

Teens also spoke of their efforts to reconcile different social histories and acquire 'accepted' identities. As teens explored questions of identity they talked of reconciling their personal and family histories with the social histories accorded value in their new communities. Some teens, particularly those in contexts that expressly valued 'differences' like bilingualism, or when they had opportunities to draw upon competencies or expertise related to their traditional culture or migration experience as resources for others, did recount positive experiences. Others saw their first language along with their social history as immigrants and their visibility as 'markers' that kept them from becoming a part of the new community.

The contrasts in experiences of teens with similar social histories living in different contexts illustrates that the perceived lack of capital is largely a social phenomenon, that is, the value assigned to capital (or not) is determined in part by the tacit rules and expectations of social organizations with which the teens or their mothers are interacting.

The participants spoke in terms of their own experiences, dilemmas and struggles. In some instances they made links between their experiences and broader social or health policy issues. Smith, (1987a,b, 1990) like Bourdieu, directs the analyst to make manifest the

ways in which peoples' - women's experiences are socially organized. One of the most explicit examples was in the ways these women's paid work roles often made them unavailable to their children. The less desirable forms of work - often the only paid work available to immigrant husbands and wives - take place at nights, evenings and weekends and is frequently of low pay and without benefits. While families were creative in stretching financial resources and in arranging childcare, their choices were constrained. Teens were often in charge of younger siblings and were themselves without supervision. All teens were looking to explore fields outside of the family but there were only a few who were involved in supervised activities and these were usually free community based programmes undertaken at the suggestion of adults like parents or teachers.

It is often assumed that teens 'get into trouble' in part because their parents are ineffective or uninvolved. Such lack of involvement is often presumed to be a consequence of indifference or ignorance. However, the experiences of the parents in this study was one of struggling to maintain values and protect their children against the lure of night life or the appeal of making money instead of attending school. These teens, particularly in Britain, were not in schools that offered extensive after school sports or arts programmes. These teens had generally not become the focus of positive attention by others. These stories illustrate the ways in which youth are given the message that they are expected to go along with the status quo and fit into the rhythm of adult work commitments, school and family life. These stories begin to flesh out the ways in which being overlooked is experienced. They also prompt us to look more closely at what consequences can accrue when, for a variety of reasons, a teen is not seen to 'fit in'.

The participants' accounts also illustrate that, in general, health is discussed in terms of absence of illness and health promotion resources they drew upon were largely related to early childhood. Specific references were made to barriers some faced in accessing screening programmes. These were secondary to language barriers or lack of familiarity the health condition and related risk factors.

Summary

This chapter has introduced the families who participated in the study and provided an overview of their reasons for migrating and their approaches to settling in Britain and Canada. In describing the participants' approaches to settlement, the data illustrate some of the challenges families faced as they realized the limits of their *habitus,* and sought to acquire capital and transform *habitus* to navigate new fields.

The participants' stories illustrate the myriad of ways newness of the environment challenged their assumptions, their *habitus*. These accounts also tell a story of human relationships and the important role they play and the types of challenges mothers and teens faced in establishing new relationships in a variety of contexts. These women needed to trust their instincts and to put themselves in others' hands. While for some this trust was not rewarded for many it was and this in turn led to the creation of friendships and the development of a community network that was both drawn upon, and contributed to, in subsequent years. Having an ally in the settlement process eased the many transitions. As these stories suggest allies were for some, 'strangers' who offered a welcome and for others, people involved with the work of different types of community based voluntary organizations.

Safety within the community was a particular concern for families in Britain. The participants' accounts introduce us to some of the ways being seen as different could compromise safety. The data also offer an understanding of the multiple ways in which language competency can, depending upon how it is viewed by the broader society, be both a form of capital and a liability or source of negative capital, particularly for teens. English is appraised as capital of value in entering new fields, establishing one's legitimacy, developing new relationships and capital drawn upon as they sought to capitalise upon credentials and competencies acquired in their countries of origin. Speaking English with an accent however becomes a marker signaling a participant's status as a 'newcomer', someone without a shared history. Speaking English also made it possible for women to function independently of their husbands, an issue that was particularly important for women who were facing separation or divorce.

The families' experiences in fields such as the paid or voluntary work force draw attention to the ways broader social structures influence women's capacities to manage. Even though many of the participants were well educated and had considerable work experience they faced great difficulties entering the workforce. Additionally, the constraints of work places and the lack of resources to assist families with childcare stretched family resources. One context in which this had an impact was on the parents' time and opportunities, to be involved in the ongoing day to day experiences of their children. The focus of the analysis in this chapter offers insight into the role of the informal sector as both interfacing with, and contributing to, the resources of the formal sector as a resource for first generation immigrant families.

A surprising finding was that even though the participants were dealing with a number of health issues in the family, and this study was presented as being about health, the

overriding concerns of the participants were related to issues of marginality and the ways this influenced their efforts to establish connections with others in the community. In the chapter that follows the differences in the ways the teens and their mothers approached this challenge are examined.

Chapter 5

Intersecting and Diverging Fields:

Dynamics of Intercultural and Intergenerational Relations

As introduced in the preceding chapter, a central theme that permeated the study participants' migration stories were the families' efforts at establishing community within the new social context and acquiring the knowledge, skills and competencies to participate fully in society. The preceding chapter also drew attention to the ways in which the new social context challenged the family's *habitus* thereby prompting a re-appraisal of family roles, competencies and expectations. The participants' accounts also provided insights into the ways in which structural constraints influenced participants' capacities to manage. That is, considerable efforts were expended in overcoming such barriers as managing with limited financial resources, meeting family needs while working with and around workplace constraints and seeking alternative employment when their credentials were not recognized.

The participants' stories illustrated the ongoing nature of community building and pointed to some of the difficulties associated with being on the margins. All of the participants were engaged in realigning their relationships with their own cultural communities as well as establishing connections with the broader community. The resulting social networks for some became sources of information and support and as such provided means to acquire new forms of capital. For others the nature of the interactions in new fields drew attention to a lack of capital and created uncertainty about their social location. Bourdieu (1990a) discusses the dynamic of such relationships in terms of the differential capacity to appropriate capital and social power and declares these function as symbolic capital which enables the individual "to secure a positive or negative 'profit' of distinction" (Bourdieu, 1990a, p.140).

Parents and teens are, for the most part, seeking entry to different fields and hence are seeking to develop different forms of capital. While establishing connections was a challenge for all, the nature of the challenge for the teens was qualitatively different than that of their mothers. That is, the stories suggest that in part because of their developmental stage, in part because of their position within the family, and in part because of the fields to which they are negotiating entry, the challenges faced by teens are different from those of their mothers. As suggested in the preceding chapter teens were expected to fit into a parental, school and community agenda. An agenda that rarely sought to consider their input. The teens generally had fewer personal resources to draw upon than their mothers and were therefore more vulnerable because they saw themselves as having fewer options. Further, the

teens' situations were compounded by how they enacted their developmental stage within the family.

Bourdieu has conceptualized relationships in terms of exchange of capital according to the social conventions of different contexts. Not surprisingly, the data indicate teens generally have less capital to draw upon than their mothers, but in seeking to be more independent of the family many teens cut themselves off from the capital available within the family. In what follows I examine intercultural and intergenerational relationships and the ways these influenced teens' capacities to develop and mobilize capital and often resulted in teens having negative distinction (being viewed by society as problems or nuisances).

Pressures to transform *Habitus*

Intersecting fields: Intergenerational Relations

The relationships of importance to mothers and teens are both functional, in that they are necessary to get on with life, and affiliative. Evident in the discussions are the ways these new relationships make manifest pressures to conform. The tensions between maintaining the integrity of *habitus* and transforming *habitus* were in evidence throughout the interviews. Of importance here are the difficulties and the nature of change demanded by different fields and how the tensions associated with competing demands were played out within the families.

The fields of interest, or importance, to teens were often quite different to those of their mothers or families. Upon examination of the 'relationship' data category differences in who relationships were established with and for what purposes, were evident. Teens were particularly interested in becoming part of friendship groups. While parents were supportive of their teens making friends this was also a major source of concern and worry.

As the mothers speak we gain insight into their feelings of vulnerability, or the sense that what is characterized as the culture of Canada or Britain is, or may be, directing their daughters to engage in behaviours that they view as improper and also potentially placing them at risk. While mothers whose daughters were still young teens raised these issues they indicated they were not currently concerned about them. However, all of the mothers whose daughters were 14 years of age or older expressed concern and worry about how to keep their daughters safe and in particular how to deal with different expectations on such topics as sexuality, social activities, substance abuse and/or dating while also guiding their teens towards pro-social activities.

The dilemma about how to respond to this concern is captured in the following summary comments the researcher made in one interview after the mother had used part of the interview time to discuss her worries with her daughter.

> res - The question as the parent is, I worry about this, so how can I protect you?
>
> Mother - Yes, exactly.
>
> res - But your question (speaking now to the daughter) is, I'm fifteen, I want to be with my friends
>
> Teen - Yes
>
> res - and how can I get some support from my family?
>
> Mother -Yes, there you are.
>
> Teen - Yeah (02, int.1, Britain, p. 11-12).

Similarly, a mother in Canada indicated that despite her daughter's success at school and positive accomplishments outside of school her worries lie in the social domain and she, like the mother speaking above, is concerned to make sure her daughter is safe. In seeking autonomy from the family this teen, like others, has distanced herself and is deemed to be showing a lack of respect for parental wishes. This distancing also has the effect of limiting opportunities for the parent to offer guidance or support to the teen.

The teen on the other hand expresses frustration at her parents' lack of understanding of the demands of the social contexts and challenges she is facing and, like other teens in the study, attributes this to the fact that her parents did not grow up in Canada (or Britain). She compares her behaviour favourably to that of her peers, who are from a number of backgrounds, and argues that her parents should be happy with her.

> Teen - There are things they (meaning her parents) just don't understand, you know, like, um, I guess they grew up living like in a different, everything is just different. But they expect me to be just like them (laughs). But, it's sort of, it's just different, you know, like it's normal to go out with friends but then they think it's a privilege to be able to go out with them. I don't know, just certain things like some of the things (that) aren't really important to me, they think it's really important.

Later in the interview the teen observes that currently her parents have 'backed off' somewhat and comments that she has 'kind of been working on them for a year' so it's 'not as bad as before'.

Teen - I'm thinking that they're just more like aware or just, do whatever then, 'I (meaning parents) don't want to argue with you' (meaning herself), you know?

res - That they've sort of resigned themselves?

Teen - yeah. But like seriously, I feel like, you know, there are people you have to worry about, there are kids you should, parents should, worry about but I think I'm not, I shouldn't be one of them...

res - What's the difference between you and those kids?

Teen - I know what I'm, I know my limits, you know, like I know what, what's right and wrong. Like they feel like if you had, kind of like, I don't know like they (my parents) always are afraid of people turning bad, you know, like kids turning bad and I just think, you know, it's whether you can resist peer pressure or not and I'm - I know me - you know, I am myself, I know that I can resist peer pressure and like I know what to do and what not to do and like it's just, you know, I'm okay, I can handle myself. Don't worry - like whatever you're (meaning parents again) stressing about, I stress about it too, you know, you don't need to bring it even harder on me. .... It's like bad enough that I have to put so much pressure on myself that you (meaning parents again) don't have to add on top of it. And, like they used to be, ' Oh, I don't like those friends of yours, I don't like those friends... it's, okay, it's fine, like trust me. I know what I'm doing, you know? Like, I don't have to do whatever they're (meaning friends) doing (33, interview 1, Canada).

In speaking, this teen makes a plea to her parents to trust her judgement. She also acknowledges that her friends do engage in some activities that she has chosen not to engage in and outlines how well she does in school and in her outside interests. For these reasons she feels her parents should give her some leeway. An ongoing point of contention is her parents' expectations that she keep them informed about her activities which includes advising them of her plans when she is out. This, she observes, stands in contrast to the freedom accorded her friends.

> Teen - A lot of my friends, just go: ' I'm going out with friends'. And then they go out. Me, I have to write down like a phone number, okay, first I've got to tell them where I'm going, exactly who I'm going to be with, write down phone numbers, yadee, yadee, yah. Okay, like I do that. Like it's just the way they are. They, it's just their personality like, they kind of stress out a lot.

res - But (laughing) you go along with it because?

Teen - It's just the way they are (33, interview 2, Canada, pp. 14-15).

Later in the interview she concedes that her parents' perspective has some merit.

Teen - Well I think it's, I think it's good that they don't let me just do anything because I do have friends and their mothers, um, it seems like they don't care about their kids (33, interview 2, Canada, p. 16).

This teen also reveals that she and her friends have had discussions about the conditions that make a kid 'turn bad'.

Teen - I don't know how I would turn out. Like I say, like me and my friends, we have discussions about this. If someone, if they turn bad, turn bad meaning like they do drugs or like whatever, is it because of them, or because their parents let them do so much or friends, is it because of friends? And, it's sort of like a little bit of everything...But then, I think parents do play a role sort of, so I don't know. I think, I just, I sort of understand how hard it is to be a mum but I'm just trying to let them know like (pause) (33, interview 2, Canada, pp. 14-15).

Although she acknowledges the concerns her parents may have about unhealthy or antisocial behaviours like smoking or drug use, this teen conveys a sense of confidence in herself and her ability to handle the situations she faces. She also argues she can appraise the situations she finds herself in. She challenges her parents' expectations with the observation that in this new Canadian context there is a different view of what is 'normal' or acceptable for teens.

Capital - *Habitus* - Field

Teens Challenge the Family *habitus*

While similar discussions are held between most parents and teens the major difference for families in this study is the nature of the capital teens set out to acquire. For these teens it is important to become part of the broader social group. The apparent forms of capital needed are ones many of the parents do not value and in some instances view as a threat to the family and to the teen's safety. Further, some teens, especially those who are not doing well in formal settings such as school, are particularly vulnerable because they seek connections that offer them affirmation they are not receiving elsewhere.

The teens can be seen as engaged in transforming *habitus* . They are seeking out new ways of interacting and acquiring capital of value. However, it is clear there are aspects of

this transformation that are problematic. As Bourdieu (1994) tells us, *habitus* exerts a pressure to conform.

> "Doing one's duty as a man means conforming to the social order, and this is fundamentally a question of respecting rhythms, keeping pace, not falling out of line. 'Don't we all eat the same wheatcake? ...These various ways of reasserting solidarity contain an implicit definition of the fundamental virtue of conformity, the opposite of which is the desire to stand apart from others...The eccentric who does everything differently" (p. 157).

Teens were frequently accused of challenging the family, of being the 'eccentric'. Such processes of challenge appear to be integral to the teens' engagement in exploring 'who they are' and determining their 'place'. These issues were introduced and discussed by all teens in the research interviews. They also however, draw attention to the extent to which these new communities challenged the social order of the family. The social order, rhythm, what was often referred to as the culture of the family creates a kind of organization with its own rules. Bourdieu (1994) identifies these as providing structure and form to family (or community) relationships. The challenge to the family *habitus* from within by teens occurs at the same time the family is becoming aware of disjunctures between *habitus* and community.

> "Every established order tends to produce (to very different degrees and with very different means) the naturalization of its own arbitrariness. Of all the mechanisms tending to produce this effect, the most important and the best concealed is undoubtedly the dialectic of the objective changes and the agents' aspirations out of which arises the *sense of limits,* commonly called the *sense of reality,* i.e. the correspondence between the objective classes and the internalized classes, social structures, and mental structures, which is the basic of the most ineradicable adherence to the social order" (Bourdieu, 1994, p.159).

The preceding chapter introduced ways these families were coming to realize their social location was shaped by societies' rules and preconceptions of immigrants. So too, the teen speaking above indicated that defining her 'place' is an issue of current concern and one she has been reflecting upon for some time. An issue she sees as shaped by her cultural identity, her social and academic interests and her abilities. The account illustrates in part how she defines her own social location and in turn how she responds to the ways others treat her. This teen views the expected family order as limiting. Having the ability to access different domains and their associated realities thereby expands her view of possible limits.

This new reality is not however, one her family has access to, and it is one that challenges what has been for them an expected social order.

> Teen -...I think I'm fortunate to be able to - I know how to speak English and I know how to speak Chinese both fluently.
>
> res - uh hm,
>
> Teen - So I have friends from both sides, and um, I like them, I like all of them. They, they're all different in their own ways and I feel like Chinese it's more, I feel that they're more-, they're like, more, more, - friends are more important and white people, sometimes like they're fun, really like fun, outgoing, but in a way some people can be really ignorant like, I see a lot more back stabbing in their group of friends, a lot more, a lot more parties, you know, and I don't know, it's sort of, I'm sort of weird, sort of, there aren't a lot of-
>
> res - You sort of feel a bit like, different from everyone you mean? When you say weird, do you mean you can step into both worlds?
>
> Teen - yeah....
>
> res - and yet, you don't really feel completely like that, either one?
>
> Teen - Yeah,

This teen's engagement with others has prompted her to reflect on what is important in friendships as well as challenging her to assert herself. Throughout this interview the teen reveals the tensions between the evidence that she is 'doing well' and what are for her parents, the uncertainties that surround her activities with different groups of friends. She does however feel that she can straddle different friendship groups, groups with different interests and orientations. As well this teen has established multiple connections though school based clubs, student council, sports and music. As such, her connections extend beyond the family, the cultural community and the immediate neighbourhood and, as she recounts, have her 'crossing social boundaries' within the school she attends.

With two exceptions, the teens interviewed in Canada all spoke of being able to access multiple fields and as a result were able to develop new competencies, usually at no, or limited, costs to the family. Many of these were school sponsored events but as indicated earlier they were also through church and other voluntary organizations. In each case these were activities for teens that had adult involvement (or supervision).

Teens also engaged in learning about others' families and day to day lives. This information is, in turn, brought into their discussions with their own families. Having taken advantage of opportunities to explore new social terrain and having competencies in two

languages allows teens to interact with comfort in these varied contexts, many of which are unfamiliar to their parents. And although it's a source of concern for parents teens do not see it as a problem.

> Teen - There's not a lot of people, at least in my school - in my grade - that are like me and I know that and everyone knows that too. Sort of my Chinese friends think I'm totally banana[5] and my white friends think I'm more 'Chinesy' than all of them. You know, but that's okay. I don't know, you sort of have to give up something. I learned like last year, it was kind of stressful for a while because I didn't know where I belong but you can get past the fact that, you know, even though I have like all my closer friends are sort of like, they're like me but one step towards Chinese. No, actually, they are like me but I realize I, I don't know, I feel more comfortable with them than to, like, so I feel like, okay they are kind of like where I belong...
> Later she spoke of a group of teens who 'praise themselves because they're white'. She noted that for her it has become a choice who she spends time with. 'I can fit in, but I sort of figured no, you know, I just don't like them...I feel like they're not very loyal and I don't want to be close to them' (33, interview 2, Canada, pp. 30-34).

This teen recognizes that she has a number of competencies and, in her view, fitting in is a choice she will make, based upon qualities she values which are also qualities assigned value by others. Having such capital is perhaps what enables her to choose on the basis of what is important to her rather than allowing others to be 'in charge' of deciding for her.

Bourdieu's conceptualization of capital takes the position that the value of capital is largely determined by those holding the greater status, authority or power in a particular context. In this case, from the way this teen describes it, she has recognized what is deemed to be of value in different groups and is engaged in choreographing a mosaic of capital that in effect places her ahead in multiple contexts. Additionally however, her competencies extend to a number of arenas in which her parents hold no, or limited, capital. The pressures to conform are not only exerted by the family. The broader society has its own tacit expectations of conformity, which may also include expectations that 'immigrants' or women take on particular roles.

In several other families the teens, particularly in Britain, have not achieved such success. This is illustrated by the comments of one mother as she talks about the challenges she and her husband see themselves as facing in attempting to enact their view of appropriate

parenting in this new social setting while also guiding their daughter into social fields that will help her to succeed and away from fields viewed as problematic. For this family choices are more severely constrained than those of the preceding teen. In the quote that follows the mother refers to their experiences with their older son and efforts to be more successful with this teenage daughter.

> Mother - yes, we are in a way old fashioned. We are not 'in', in the new way like we are used to the signs of the times, mostly with my older son, most of the time. Sometimes with (daughter) but I expect (from) both of them a lot of things. But, my older son I think is, uh, a project that's not working very well and I expect from (daughter) different, yes different way that.
> res - so you're trying different things or you're expecting different things?
> Mother - yeah, I expect different things. ....
> later...after a wide ranging discussion of concerns and worries has taken place between the mother and daughter
> res- So what you are saying (mother) is she (daughter) wants to have friends outside and do things with other people but you don't know them?
> Mother - yes
> res - You don't really know what's important to their families?
> Mother - yes
> res - and whether they might be a bad influence, or they might be a good influence. You just don't know them, is that?
> Teen - All my friends are good, she don't like them, this is why she goes, she never like my friends, I mean I can't, you know I can't bring friends (home). I mean like all my friends that I have, she don't like them and I can't do nothing...I don't really mind because she's an old woman, you know she...she's saying she won't give me freedom and I want freedom because I'm a fifteen year old and she thinks that, because she's growing up in her country and I'm growing up in somewhere else (02, int.1, Britain).

Later in the interview I ask the teen if she feels her mother's expectations don't work for her now they are living in Britain. The daughter responds that she feels a bit like her mother is experimenting with her, trying to make things work out. She makes a plea to her mother to recognize the ways she does contribute to the family and make things more even.

> Teen - ...she wants me to do this, she wants me to do that, yeah, I will do it but she has to understand that if she wants something, you know, because

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[5] A term with negative connotations meaning a person who is or looks 'yellow' or Asian on the outside but views

she, she wants me to like do this and that for her, you know she will have to help me as well even because I always help her at home (02, int.1, Britain).

The tensions to conform and to accommodate to reduce the chances of being viewed as different or in Bourdieu's terms as an 'eccentric' were pervasive throughout the conversation. As the interview developed the mother indicated her concerns were that the teen's friends were interfering with success at school and potentially leading her daughter into antisocial or risk taking behaviours. Also, while this teen is bilingual, unlike the teen above, there appear to be very limited opportunities to draw upon her language skills as a form of capital. Furthermore for this teen school is a site of failure and, with the exception of being involved in a youth programme at the church (as a consequence of extensive urging from her mother), she has not had opportunities to acquire new competencies to develop areas of interest or talent. As such, by contrast, she has much less capital to draw upon in navigating different social spheres. While she is assertive in her discussion with her mother and able to speak with confidence about how she contributes to the work of the family, when speaking of other contexts she does not convey the confidence of the preceding teen. Rather, she speaks in terms of fitting in by going along with others. In discussions with me alone she indicated that she was aware that some of her friends weren't perhaps the best influence but she still felt she needed friends.

Another mother in Canada noted when her daughter reached adolescence she viewed the neighbourhood community differently. She therefore, took a second look at what was around them and decided to make some changes.

Mother - I don't want to sound like too (laughs) weird but, uh, I don't really like the high schools here because I saw that many kids, thirteen, fourteen, they start to smoke and nobody saw them (or did), anything, they're free to smoke anywhere, inside the school even,[6] I saw them and, uh, I really don't want that for my kids, I want them to be -

res - have a bit more direction, be a bit more clear about.

Mother - yeah, I don't really, I have my daughter, she's going to be seventeen now and I never see her smoking or something like that, she's very different from the kids that they go to, to a

res - neighbourhood school?

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the world as 'white' - on the inside.

[6] Although this mother saw teens smoking, this is in spite of policies to the contrary. For example, the school district and the broader community have strict no smoking policies and legislation against smoking in buildings (schools, restaurants, all government buildings and offices, etc.) open to the public. Teens and others therefore tend to congregate outside of such buildings or on the perimeters of school property to smoke. Also, in BC, it is illegal for persons under the age of 19 to purchase cigarettes.

> Mother - A neighbourhood school.
>
> res - It's a worry, isn't it?
>
> Mother - For me, yeah, because for lots of people, they, they think that it's okay, they can do that, they're old enough but for me maybe my culture is different and I don't want her to do stuff like that (23, interview 1, Canada, p. 10-11).

The mother goes on to say that for reasons like this, when her daughter reached high school, she moved all of her children to a Christian school, which is some distance from the city, but which she thinks offers them the best environment for learning. Although she describes it as a school that reinforces the views of their church community, her children are "the only ones who speak Spanish" (23, interview 1, Canada, p. 12).

In this example this mother has seen it important to choose the school, a central social field, in which her children spend their time. This choice was not without cost to the family in that it required considerable travel for the children and therefore a commitment on the part of the family, with the husband and wife both working at night to support it. Several other families spoke of the schools their children attended in both positive and negative terms. For the latter, many felt constrained by the lack of ability to gain entry to schools that would, in their view, provide a better social and learning environment.

It was not the intent of this research to focus on educational settings, however, as schools comprise central social forums for youth and are settings that are particularly influential in defining 'competence' they become frequent points of interface between *habitus* and the broader society for teens and their families. Such interactions Bourdieu and bhabha contend prompt reflection on one's place and sense of self, processes that developmental theorists view as tasks of adolescence.

The view that the neighbourhood, school or friendship groups could exert negative influences on their children was widely held among the mothers in the study. To mitigate this the parents talked about trying to involve their teens in activities or settings that shared common values and interests. Many sought out opportunities that would enable their children to develop areas of interest such as in sport or art while at the same time having them meet and spend time with other teens. An assumption underlying such initiatives was that these activities helped teens to develop skills (and the confidence that accompanies it) while also having some supervision from adults. One of the difficulties for parents was in actually getting to know who, or what activities, might be a good influence. In effect they asked what capital is valued in this new context?

Many of the mothers, particularly in London, talked about trying to get into 'better' schools, trying to live in a neighbourhood because of the reputation of its schools, enlisting the support of the parish priest to advocate for the child's entry to a particular school, or in one case in Canada actually trying to get support for changing the philosophy and approach of the school. Fees to attend private schools were not available. Most parents were unsuccessful in effecting change in schools for a variety of reasons but usually because they were unable to find housing in the desired area or their children couldn't get into the preferred school. As such, most parents worked at trying to make the best of the situation they were in.

Parents used a variety of strategies to make teens aware of the importance of education.

> Mother - I usually do part time work sometimes cleaning the house, I used to work for German people, she (my daughter) knows when I do my work and sometimes she help me with my work...I want her to see the other part of life - that ... people that have a lot of study live in a different way than us." (O2, Britain, int.1, p. 19).

This mother attempts to link a better more comfortable lifestyle with better education.

All of the mothers who participated in the study recognized that becoming a teenager marks a new era of development and they also realized this stage required they engage with their daughters in a different way. Mothers also observed that in the new cultural contexts, adolescence meant changes in the expectations, of the family, themselves and, their relationship to peers.

For example, in an earlier account a daughter called for a more 'even' relationship with her mother. Another mother described how the changes associated with adolescence prompted her to modify her position with respect to her daughter in order to establish a relationship that would enable her to bridge (fields) domains of difference.

Mother - But a few years back when she's (younger), she's a teenager now, and I keep thinking I have to, I have to try to, to communicate with her so I can be with her, for example, like she said something about the school or about her friend, I have to try to, to talk with her and to listen to what she say, so to try to befriend her. Because that is the only way.

res - So trying to have that relationship with her?

Mother: Exactly, to build a relationship with her to try to be a friend with her otherwise you, if you don't build a kind of relationship with your daughter,

it seemed a lot bigger when your daughter grow older (group 10, Britain, 11, p 15/16).

Some families, particularly those who had a say in the school settings which their children attended, seemed to have more knowledge of their teens' social group.

res - Do you think, does your mum know your friends pretty well?...

Teen - Um, well my mum knows most of my friends and, she doesn't know all of them, but the ones she doesn't know she, she, she knows if they're responsible or not, you know so I can be with them and she knows some of their parents but not all of them.

res - Right, okay, and is that because you bring you friends home or because you go and do things together with your family or, how do you sort of..

Teen - We just do things with each other. I guess like my friends from church, my mum knows them from school....

res - Do you think that makes a difference that your mum knows who everybody is?

Teen - Probably, yes, because then she has an idea of the people I hang out with (23, interview 2, Canada, p. 11).

Later in the interview we discussed connections that this family had maintained with cultural traditions. Here the teen drew a distinction between the different ways teens' behaviours in each context might be viewed. That is, the teen gave an example of differences in expectations about fashion. She noted that current teen fashion for girls in Canada would be viewed differently, much less positively, in El Salvador. She also acknowledged that her mother, while traditional, realized the impact of living in a different cultural context and therefore she was given somewhat more leeway with respect to what she wore and some of the activities she engaged in, in the Canadian context than she might have been given were they still living in El Salvador.

It was clear that virtually all of the mothers in the study felt they were excluded from the social spaces or fields in which the teens' unstructured leisure time was spent. They also, for the most part, found it difficult to become involved in, or get to know, their children's schools. The importance of relationship, and of being integrated into, or being viewed as a resource within the teens' network, was echoed by the mothers. Others lamented the erosion of relationships that had taken place in their families.

Gaining Entry to, and Navigating, New Fields

These study data provide evidence that teens on the margins, those who have not acquired the capital needed to navigate the new social arenas face special challenges for which many have difficulty mobilizing support. The tensions between feeling on the margins and feeling supported are examined in what follows.

Threats to *Habitus* - Threats to Safety

The data suggests that when teens are living in social contexts where they are experiencing little success and where their cultural heritage is viewed as a liability rather than an asset, they are likely to be critical of their parents, or translate their own sense of not being valued into a critique or questioning of their parents' credibility. For example, the following quote is from a second interview with a mother daughter dyad who had in the first interview discussed the erosion of their relationship. The mother speaks about the challenges she faces in attempting to both create community and establish connections with others who share her views of family. Her daughter is engaged in both navigating this new social context and is in the process of trying to decide where she will fit in. While the daughter in both interviews clearly valued and wanted her mother's respect and support she challenged her mother and took the stance that her mother was unnecessarily concerned and in some ways unreasonable in her expectations. The teen spoke at length about how she both resented and resisted her parents' efforts to guide and "control" her.

> Teen - The more they protect me the more bad things I'm going to do. Basically because they're gonna keep me here all the time, you know, then the more I want to get out and the more I'm going to do bad things...(02, Britain, int. 1, p.14).

She goes on to say she respects the fact that families are not all the same and hence recognizes this as a source of worry for her mother. Nonetheless she held the view:

> 'I respect that. But for them, (my parents) for them to be too overprotective,...I can't deal with it, it's way too overprotective.' (02, Britain, joint int., p.15).

In the second interview some months later, the daughter has moved closer to her mother's point of view. In the conversation that follows the daughter weighs her mother's views against her own and those she has encountered in the broader community.

An ongoing concern evident in the family discourse is the view that this society, or the contexts within which this family interacts in this society, pose a threat to the integrity and safety of individuals in the family to the extent that the family has started to explore moving. This teen is vulnerable, in part because the only power she sees she can exercise is

ultimately harmful. She, like others, feels she has no credibility or authority within preferred peer groups or other fields to which she is seeking entry (i.e. workplaces) or in which she spends time (i.e. school).

What is also evident, particularly in what the daughter in the following account says, is that the desire for friends drew her away from other more pro-social activities and has contributed to the feeling that she cannot distance herself from the violence of the community. In what follows we see a teen who has moved in a full circle from being critical of her family to appreciating it more than the broader community. In the months between the first and second interview the teen had started to have serious difficulties at school and had taken a job in order to be able to purchase clothes and participate in social activities with her friends. The mother was concerned that as well as taking her away from her studies the part time job had drawn the teen into a late night circle of friends.

Mother - If I have to move to any country I like to go back to my country[7].

res - yes

Mother - because, I see the education is not like here but it costs more (here).

I don't know how I say, but for me more help in a spiritual way and.

res - So, that the ways the community works? The ways the place works..(in your home country)

Mother - yeah

res - is more compatible with the way you see the world?

Mother - Exactly, how can I (pause) Bringing up my children is important for me, because in this country it is very difficult for me.

res - you're always fighting the prevailing..

res - So what do you think about that (daughter)?

Daughter - I agree

res - Do you agree with your mom, you'd rather, do you see what she's saying?

Daughter - Yes.

res - It's hard to be here?

Daughter - Everything has changed so much, I've lost contact with normal girls that we used to see in our country regularly. ...I'm not really used to violence there is more killing, there are more rapes than in my country that would be stuff like that....

res - so you're sort of seeing that there's a different world?

Daughter – yeah...

When I was working, I wasn't paying attention to my studies, and at the end I was going, not coming to school. It's no use to work, also I got involved with friends that are not good in the sense of everyday life, but then I didn't care. In that time I didn't care what my mum said and I, I didn't realize what was the consequences. I wasn't aware. I feel a kind of fool because my mum got to a point where, yeah, okay, she let me go clubbing and this and that, at age fourteen, which is very young and...my group of friends like I, I didn't realize, I mean I was at that age, I was like into gangs, ...but to me it brought really bad consequences....It got worse and worse, at the end I didn't speak to my mum, I would speak to my mum but I would lie to her, I would always lie to her. I never told her what I did, I never told her what I did after work. I used to come home late after work, I never told her where I went...I was hurting my mum but then I realized what I was getting myself into and I got really depressed and like I didn't want to eat, I stopped eating...later...I've done bad things, I've done bad things here but not that kind of bad things, I mean because all my friends now that I know, they're all pregnant and like she (my mother) thinks that I've had sexual intercourse with other boys but I know it's not that now (02, Britain,, - 2nd joint interview, sections of pp.3,4,6,7).

While this teen values her family she, like others, rejected the parental perspective on the grounds that it was 'from another world' 'another era', and therefore not of value in the fields to which she was negotiating entry. But she then realizes entry to these fields came at a cost.

When several friends became pregnant this teen was prompted her to rethink her choices. She commented that these girls were left on their own by the fathers and one of her good friends was effectively abandoned by her own family once she became pregnant. In talking about this issue the teen's mother noted that their area of London had the highest rate of teen pregnancy in the European Union, a pattern noted in several government documents (Britain, 1998; Britain, 1999 July).

In further examining these cases the teens recounted that they were spending increasing amounts of time with other teens and were moving away from connections with family but a number of teens were also moving away from other, potentially positive, organizations like school. Unlike some teens in the study these teens, had limited or no connections with groups, organizations or activities like sports or community based clubs and

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[7] While returning to her country may be this woman's wish, it is a choice that is not available to this family. They

as such had limited access to other forms of capital and limited opportunities for guidance from others than peers. Thus, when they have difficulties at school and they're negotiating new relationships in the home they seemed to have no other forums of affirmation.

Working was seen as a necessity for many teens because their families were not able to provide them with spending money. In some cases part time work helped teens to develop a sense of responsibility and provided a source of positive feedback on their abilities. In these cases the teens maintained a priority on school and fit work into their time available.

However, in a number of cases other mothers spoke of actively discouraging their daughters from continuing with particular part time jobs because they introduced the teens to a social group that engaged in activities the parents discouraged, or tempted the girls to engage in activities that diminished the time they were able to spend on school work.

Community: Forums of Affirmation and Exclusion

Many of the mothers, particularly those whose teens were not involved in community based programmes and who were having difficulties at school, were making an effort to try to connect teens with organizations whose programmes were accessible. For these families accessible meant affordable, of interest and local. Even so frequently, particularly in Britain, the teens' or parents' choices were limited in part by a lack of funds and a lack of options and in several situations resistance on the part of the teen.

For some parents a goal was for teens to establish connections with adults other than their parents. Such connections were, in some cases, drawn upon by teens as resources for other situations. A number of the teen participants indicated they did have people in their extended family that they could turn to when making decisions, or had, through community based programmes, made links with adults who they did consult with from time to time. Such adults became resource people who could offer information and guidance and could facilitate teens' entry into different fields of interest.

Earlier in this chapter a teen discussed the ways she had been exploring different fields by spending time with friends of different backgrounds and with different interests. Through this process she described she was developing a sense of 'where she belonged'. She was receiving the message that she had a place and that she could contribute. Interactions with adults, and programmes in community organizations could also provide such exposure or in some instances create new opportunities. However, not being able to participate, or being excluded because of cost, or other criteria outside of a teen's control also delivered

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could, in theory, go anywhere but their home country.

messages to the teen about 'where she belonged'. Such messages were often ones that called into question their value and their worth.

One teen had been assigned a 'Big Sister' through a voluntary organization whose purpose is to foster friendships between adult women and disadvantaged girls or teens, teens who in many cases did not have a mother. This teen's mother had learned about the organization through discussions at language classes seven years earlier. The teen noted that it was through her long standing connections with this woman ('Big Sister') that she had gained some insight into the life of a professional woman. The teen indicated that this woman had, among other things, encouraged her to make school a priority and to consider post secondary education. The time they spent together, which at first had been weekly but had changed over the years, had been doing general activities like going to movies, playing games, or spending time with the 'Big Sister's' family, who lived out of town, during Christmas holidays etc.

While the teen indicated she benefited from the time spent with the 'Big Sister' she was also aware that this middle class professional woman lived a different life than her own family, and although it was a life she was prepared to consider entering, she was supportive of her own mother. Several times in the interview she indicated that people "didn't understand her mother," she was a good person. While the teen acknowledged that many people had been, and continued to be, very generous with her family there were some who were unduly critical.

> Teen -... so being a big family (single parent) is difficult just period and whatever, right?...I guess people try to pay more attention, I don't know, towards us because we're a big family like they always try to, they'll give us like programmes (i.e. free enrollment in community summer camps, or classes) where we can put our little brothers in and... Sometimes it's very difficult, some people are really ignorant and rude and they don't understand our situation, they always say like why can't, they criticize and you know, like make judgements and stuff, and that's kind of hard because some friends will want to do this and we can't (afford it). Also money situations, like there's a lot of programmes in (area) that help with money like they're low cost and everything but there's other programmes that you want to put people (from the family) into and it's just
>
> res - you can't?
>
> Teen - and you can't (afford it). (22, Canada, interview 2)

While the family situation was one that challenged a number of conventions, the daughter who was 16 demonstrated she was able to navigate a number of social domains very effectively. She was popular at school with both teachers and other students. For example, as well as doing well academically she had been invited to participate in a number of school sponsored activities, like sports or band tours. Unlike many of the other participants she did therefore have a number of adults who were in a position to be resources for her. Additionally, for this teen, knowing Spanish had become an asset as she was able to capitalize on it particularly in school. It also helped her to define her 'place' in Canada as well as to maintain connections with her heritage.

> Teen - I was just going to say bilingual, like being bilingual it's um, I think it's really
>
> res - an asset?
>
> Teen - It's a good advantage especially in this country because it's so many cultures, - multiculturalism - so it's really good to know (22, Canada, interview 2, p. 17).

A number of other participants successfully transformed their first language skills into assets for the workplace and also saw this as a skill for their children to develop.

> Woman - but, for me it's pretty important, you know, to have the credentials, you know, to know more experience, you know and speak two or three language, even for my job, it's very good.
>
> res - uh, hm
>
> Woman - you can have more opportunity.
>
> res - So you see learning different languages as a skill for work?
>
> Woman - oh yes, yeah, I can see them going to apply for a , you know, for a job, they ask how many language do you speak,
>
> res - when you apply for a
>
> Woman - for a job (21, Canada interview 2, p. 10).

The value of having multiple connections with persons in different fields and with different perspectives is manifest in the following discussion about decision making. This teen, like others, involved people from different fields as resources when she is making decisions.

> Teen - ... I always discuss my thoughts so I usually really, I have like two really close friends who I always, like my age, so I discuss with them, that's (the future) always a topic that is kind of, you don't really want to think about because you're like, oh no, oh my gosh, we're going to get out of school

soon, we're going to go to post secondary, it's kind of scary but then when like adults ask you or when, you can talk to your counselor (at school), your counselor is always like the number one person you talk about because you'll have so many questions. Okay, how do I do this? How do I do that? and then they ask you - What are you interested in? and they give you ideas and stuff and that kind of helps you look for that right track, you know, and especially since you're living here and you know, you're probably going to live here for like

res - in Vancouver you mean?

Teen - Yeah, like or in Canada itself right, so you have to find something that balances out I guess because if it's something you like or something that will be a good job right?

res - em, em

Teen - I guess, I usually talk to my 'Big Sister' too, I have a lot of people who give me advice and I can talk to them.

Later the teen talks about how she considers the advice she receives.

res - Okay, but you do want to take charge of some things yourself too, right?

Teen - Yeah, of course, yeah. So I will ask people for advice or ask them for their opinion - but if I already know what I want basically -(pause) because sometimes I'll ask and then I'll be like no, (laughs), and I'll like decide myself, I'm like, 'I don't know why I asked this'. I knew already but I do want to take decisions a lot on my own like I want to be quite independent when I get older. You know like when it's possible for me to live on my own and, you know, not, really have to depend on my mum because she already has enough stress as it is, so I don't know, I would like to help her out as well, but like just people look up to me more than I have to be leaning towards someone from the outside (22, int. 2 Canada, p. 17)..

Here as the teen describes who she consults with and how she considers their input she gives us an indication of her own sense of competency, that she sees herself as someone who can be depended upon rather than someone who depends upon others. She sees herself as having a capacity to act to pursue her goals.

This positive sense of self was conveyed in our meeting. My reflections after the second meeting with this teen were that she was:

> "very capable, proud, very clear about her heritage, respectful and protective of her mother. She speaks of her family in a positive way. This being the

case she also conveyed that she was aware of how an outsider like myself, would likely view the state of the home and perhaps their family life. For example, when I arrived for the interview, the teen, who was casually dressed in clean clothes, with her long hair groomed and pulled back, greeted me warmly, offered me a seat in the kitchen at the table and cleared away the previous evening's and the morning's food by stacking dishes beside the sink. She then apologised that her mother wasn't able to be there at the moment but indicated that she would join us shortly. The teen sat down and attended to the interview while with apparent ease disregarding, the broken hardened eggs on the floor, the spilled milk on the table and the cockroaches crawling on the table and walls. When the mother did join us, she demonstrated an awareness of the disarray of the household and acknowledges that I would likely have a different perspective on it by commenting, as the interview was ending, that she would 'get to work to clean her house now' (22, field notes, Canada).

This teen, like others, was exploring 'where she belonged'. Her interactions with others provided opportunities to consider what goals she would set for herself and she did not seem to need to reject her family in order to gain entry to fields of interest

Another teen, when asked if she had people outside of the family with whom she could discuss concerns, provides a contrasting account.

> Teen - All my friends, I know they're not real friends... There's counselors but... I don't trust any, I don't trust anybody. I've gone, I'm going to a bad school (02, Britain, interview 2, p. 8).

This teen's comments illustrate her realization that within the context of school and community no support is forthcoming. Some teens, like this one, received little positive feedback from the broader community about their personal value and strengths. The messages this teen received about 'where she belongs' have placed her on the margins. Despite efforts on her mother's part to guide and protect her, guidance she has largely rejected, the teen feels without support.

Reflections on Teens' Perspectives

The teens' experiences presented here frequently challenged *habitus* and disrupted the taken for granted expectations about a host of topics including family life, community, education and work. The teens' accounts however illustrate the importance of being successful in gaining entry to fields and in acquiring capital.

Bourdieu offers insight into this relational process. He observes, individuals exist as agents "who are socially constituted as active and acting in the field under consideration by the fact that they possess the necessary properties to be effective, to produce effects in this field" (Bourdieu & Wacquant, 1992, p. 107). Note that Bourdieu does not equate being effective with having an effect. For many of the participants, both mothers and teens in some fields or contexts, they could describe an effect, but they were clear that the 'effectiveness' of their participation in the field was frequently compromised because of a differing *habitus* and lack of capital. Creating an effect, for some meant challenging or contesting the rules of the field and in so doing asserting the value of their own capital.

These accounts help us to see that many of the mothers (parents) were not viewed by the teens as possessing what was needed to be effective in several of the fields (school, leisure) of importance to the teens while daughters were exploring new social fields. While several of teens had a number of doors opened to them for others, the doors seemed closed. It is these teens who seemed particularly vulnerable. It is important to note, in appraising how people respond to their circumstances, dual influences of the individuals' mobilisation of capital and the social organizational recognition of the value of such capital. As teens and their parents have somewhat different *habitus* there is frequently tension between them. This tension is manifest in family relationships. Each agent, teen or parent, exerts an influence that aims to both conserve *habitus* and to accommodate or respond to the changing contexts.

Relationships between parents and teens have been the focus of considerable scholarly work which has largely focused on the impact of the teens' developing autonomy and independence on the family. However, when we draw upon Bourdieu's concepts to examine the relationships between parents and adolescents in these first generation immigrant families we see the possibilities for accumulating different forms of capital are, for many of these families, severely curtailed. Being 'good' parents, or effective parents, requires more than clear values about family or morality. All of the parents who participated in the research can be seen as sharing similar views about the importance of education, family, honesty etc.

For parents, having limited capital viewed to be of value means they have fewer resources to draw upon to guide their teens through this developmental stage. One manifestation of this is the constraints on their ability to access new forums of information and resources. These teens, who are living in social contexts that value independence from the family and social and financial autonomy, the opportunities to acquire the skills needed to exercise these social freedoms are in many instances curtailed.

While in both countries involvement with church based programmes was high, families in Canada were much more likely to have taken advantage of other community based programmes than those families in Britain. From the families' comments this seemed to be largely a consequence of accessibility and availability. In two instances in Britain when the teens were older (over 17) the mothers started to involve the daughters in work roles within the voluntary organization.

Experiences that located the teens and mothers on the margins had negative effects upon their relationships within the family and the community and in many situations led them to question their own value. A consequence of migrating for families was that many of their assumptions were challenged. While all families expected life to be different, the realization that what one anticipated or expected (for the future, or even for the family in the present) cannot be counted on, induced in many a sense of powerlessness. In working through the issues associated with establishing connections and friendships in their new communities, both mothers and daughters were prompted to reflect on what was important to them, who they were, what their futures held out for them and how they fit in these new countries.

Such questions led many to ask how much (of their fate) was under their control and to what extent was their future their choice? As illustrated in this chapter these teens, like others their age, were actively engaged in exploring their own sense of self. Their explorations however were strongly influenced by how others viewed them, the categories to which they were assigned by others and how their circumstances facilitated or hindered access to opportunities and experiences. Some teens, particularly those who experienced success in a number of formal contexts, and as such had capital, conveyed a sense that they had a role in defining their sense of place. Others, particularly those with a limited network and whose abilities, experiences or talents went unrecognized or had not had the opportunity to develop, were less able to challenge others' placement of them and sought acceptance in other ways. These latter teens were often particularly critical of their families and did not see them as resources. For both teens and mothers, experiences that led to exclusion had negative effects upon their relationships within the family and with others in the broader community.

The accounts suggest that in the parents' views schools are key sites, or fields, in which teens gain confidence and acquire competencies. The teens' accounts suggest that this assumption is not always accurate and for some teens schools are sites where they are repeatedly reminded of their marginal, 'less valuable', status in society and sites of failure.

The teens' views are in keeping with findings of a number of recent population based studies undertaken in Britain. These have identified schools as sites of social exclusion (Campbell & McLean, 2002) and made links between school achievement and health inequalities (Gordon, Shaw, Dorling & Davey Smith, 1999). The importance of education is evident in Wilkinson's (1996) population based research undertaken in several countries including Britain and Canada that has established links between level of education and health. He further takes the position that an investment in education is an investment in community capital. In addition, West (1999) who also worked with British population based data, has documented links between low educational attachment and future health and class position and also noted that youth who are disengaged from school and who engage in risky lifestyles are more likely to have poorer health status and be under employed (West & Sweeting,1996). These researchers' work and the research of others (Ostberg, 2003) draw attention to the importance of the social climate in schools as influences on continued school involvement and mental health. The impact of this is augmented when teens are living in conditions of material deprivation (Sacker, Schoon & Bartley, 2002).

Summary

In this chapter the participants' accounts are drawn upon to illustrate ways mothers and teens seek to establish connections with others and the difficulties that can arise when teens do not have competencies or capital deemed necessary to access new fields. Establishing relationships was particularly important for teens and while in many instances these were sources of support and avenues to new information and opportunities, in other cases they competed with family or school.

Resource persons within the community played a role in enabling teens to acquire new competencies or capital and to meet such developmental and social needs as developing independence, gaining confidence in the self, and exploring and defining the self. In some community contexts barriers to access existed and were for some particularly difficult to overcome. Barriers for some took the form of lack of material resources, but in other cases it was the lack of social capital that drew teens' attention to their negative 'distinction' and in some cases prompted them to think about themselves and their families in negative terms.

The analysis of the teens' and mothers' accounts presented in this chapter also illustrates ways in which context, and one's actions within in it, have historical and social elements. Actions can therefore be seen to be influenced by *habitus*, or one's perspective on how things 'should be' but also by the ability to enact agency and to access 'resources' or

capital. Similar issues are raised in the debate about the relative roles of structure and agency in determining action.

Bourdieu's perspective, and the participants' accounts, show a recognition by the teens and their mothers, of the individual's agency or capacity to act or choose. As such, one may accept or challenge the 'rules'. Bourdieu however urges us to consider what he refers to as 'real choice'. That is, Bourdieu suggests that in theory one has many possible choices but in fact action is constrained by what choices are actually within one's means or reach, by what is available, or accessible. For some teens, the possibility of gaining entry to fields was mediated by the ways such fields assigned value to (or devalued) their capital.

These accounts introduce processes that contributed to teens' sense of being 'assigned to the margins' and illustrated the ways this influenced, often negatively, their views of themselves. In the chapter to follow the concepts of marginalization and exclusion are explored more fully and discussed in relation to the British and Canadian policy contexts.

Chapter 6

Experiencing and Challenging Marginalization

In this I chapter examine marginalizaton as a concept central to the study participants' experiences. To do so I build from the preceding chapters that illustrated ways marginalizing practices permeated the participants' day to day lives and draw upon Bourdieu and Smith's concepts to re-examine this analysis.

Here, the concept of social capital is used to illustrate how the social situation could define or redefine a person's value and influence relationships. A teen or a mother in one context may receive messages that she is competent, important or a person of value while in another this same person may receive messages that convey the converse; that she is not welcome, she has no attributes of value. How participants responded to the complexities of the social situations they faced are also examined. This chapter then, draws upon Bourdieu and Smith's concepts to examine the processes that contribute to marginalization and individuals' responses to it and to consider ways forward. Bourdieu and colleagues (1999) characterize processes of marginalization as including situations in which persons are constructed by others and in some instances by themselves as 'other', as 'outsiders' as persons who do not share the same *habitus* or who did not hold the necessary capital to navigate particular social contexts. While marginalization has not been a concept central to Smith's (1987a,b; 1990) work her analysis of the ways women are excluded from the prevailing social order aligns with this view.

Bourdieu contends that the analyst's task is to make visible the ways social structures organize such experiences. His analyses of marginalization characterise it as the process leading to exclusion. Bourdieu (1994) contends that to foster change the taken for granted 'order', and the rules that sustain it, must be analysed.

> "...When the dominated have the material and symbolic means of rejecting the definition of the real that is imposed on them through logical structures reproducing the social structures...the arbitrary principles of the classification can appear as such" (p. 164).

Smith (1987a,b,1990) has also made the relationship between the dominator and the dominated a focus of inquiry. She directs us to make visible the ways the social order organizes women's experiences. Smith (1987a,b,1990) illustrates how systematic exclusion from processes that define the 'social order' can create contexts that invalidate women's viewpoint. Her work shows how the ideological premises of policy and the assumptions upon which systems are developed to implement policy can systematically privilege some

groups. She directs us to identify the points of disjuncture and/or congruence between women's experiences and ideological premises or discourses underpinning policy as a means for understanding the mechanisms of, or remedies to, domination. Implied in each of these positions is that formal power is assigned through institutional processes. In drawing upon these theorists' concepts to make sense of the participants' experiences different aspects of marginalization become manifest. One is the ways these experiences are socially organized. That is, how *marginalization is shaped by practices of the broader society.* Such practices include actions of individuals and the ways such actions are sanctioned by broader society. The second is that the *criteria being applied to justify marginalization are derived from assumptions about 'categories' of people,* not about a particular individual's abilities. The third is how these conditions contribute to *the experience* of being on the margins; what it feels like, how meaning is assigned to it and the ways it prompts the individuals to reflect upon themselves and to establish (or limit) relationships with others. In this chapter these aspects of marginalization are explored.

Marginalization: A Socially Organized Experience

The preceding chapters demonstrated how institutional processes could, and did, constrain choice and contribute to experiences of marginalization. For example, how work roles could limit the ways childcare and adolescent supervision was undertaken by families, particularly single parent families, how the availability and accessibility of programmes and activities for youth influenced opportunities for teens to acquire new forms of capital, or the ways 'institutional' responses to bullying or violence could influence participants' views of the extent to which such events were tolerated by the broader society. Similarly participants spoke of the ways downward mobility and the lack of recognition of capital contributed to persistent feelings of being on the margins of their new communities. These examples illustrate the ways the women's experiences were socially organized.

The exploration of the fields to which teens and their mothers were seeking entry, undertaken in Chapter Five, illustrated the social processes involved in navigating different social forums and the types of criteria for entry that applied in different contexts. These criteria, in many instances, also located the participants "on the margins'.

Not being seen as having capital necessary to access work roles, despite having experience in their own countries, contributed to feelings of being assigned to the margins and to feeling underestimated and undervalued. The participants discussed the difficulties they faced in gaining entry to fields using the language of exclusion.

In a number of instances participants were bullied or were victims of violence. The accounts illustrated the ways such social exchanges could convey messages of exclusion.

However, when persons in authority challenged such actions, participants felt supported. This draws attention to the importance of institutional recognition of such injustices and illustrates the possibilities change could offer.

In what follows I examine different aspects of marginalization, to illustrate the processes of defining and redefining social spaces and the tensions between seeking to belong and being assigned to the margins on the basis of unchallenged assumptions.

Marginalization: A Consequence of Categorization

The participants all discussed the 'markers' that led others to construct them as immigrants. Being constructed as an'other' is one way participants were reminded that they have a different history and in some instances that they 'don't belong', that they are not 'equal', that they are 'in a house that is not theirs'. In effect to assert the view that they hold negative social capital. Being assigned a place on this basis was problematic.

> Mother - The problem is...the majority of the Latin American people has not, um, a clear way to go...They have no position in this society. The issue is you have to win a position in this society, you have to work very hard (02, Britain, int 1, p. 7).

Evident in the above account is the notion that this family is seen first as 'Latin Americans' and as such they do not have a place in British society. This mother responds by attempting to ensure her children work hard to win a position. 'Doing well' requires developing the capacity to move outside of the circle of immigrants. For, in this mother's view, continuing to be a part of the immigrant group will mean her daughter will be unable to 'win a position'. While she realizes her daughter must work within the rules of the new cultural context, this reality also presents a dilemma because she values her connections with, and the traditions of, the cultural community and these are viewed as a liability.

While parents were supportive of education as a means of gaining access to the broader society, some were nonetheless skeptical. Their experiences led them to consider the possibility that credentials would not necessarily allow them to be viewed as other than a refugee. In speaking, participants convey a sense they will never be part of the fabric of society. One father discussed the difficulties his children face:

> "They are not really welcome into <u>their</u> society...because they are, um, why us because we are foreigners, because um, we have not the same language, we have not the same culture and especially, especially because we are refugees and you know what that means in this, in this country" (04, Britain, int. 1, p. 25).

He observes that some people are able to complete university in Britain and get good jobs but for the majority:

> "At the end of the day, they finish doing the jobs the other people here don't really want" (04, Britain, int, 1, p. 25).

His comments suggest, there is a place for people like his family, but it is a place on the margins where others don't really want to be, not at the centre.

This sense of being assigned a place, on the basis of criteria that may or may not have any real relevance to a person's abilities permeated the accounts, particularly in Britain. In the account that follows a mother comments that despite citizenship she and her children are visibly different and can be singled out at anytime. She describes how she prepared her daughters to respond.

> Mother – I try to maintain some connection with our cultural heritage but - although they were born in the west and live through their life[8]...and there's nothing wrong with being in the west, it's just somehow prejudice exist. Um, so I
>
> res – em, um
>
> Mother – um, so I mean we, we have black hair and black eye and dark skin, it doesn't matter what culture you are or you, you adopt, you stand out.

She therefore taught them how to stand up for themselves and ensured they knew their rights.

> Mother – When they were younger, when they were in school, um, I would say to them things like, if anybody, you know, bully you, you come home and you tell me and I deal with it, don't fight but....I'll take it up. I think that's always an issue especially in Britain...I think I, not train the children but give them enough information for them to stand up for themselves, they would have confidence to speak and know their rights to be here" (12, Britain, int 1, p. 10-11).

In addition she presented herself as an advocate for her children to convey the message that 'you are not in this alone'. She also encouraged her daughters to further their education. In this vein she recounted her own efforts at furthering her education.

> Mother – For two reasons I'm doing it or I've been trying to achieve...as a woman, um, in any society women are always, you know, kind of like second citizen, um, but the other one was because you, - woman from ethnicity minority – have it worse, I think people don't give you credit...and it's a

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[8] The migration route for this family was from the mother's country of origin to a western country, where her daughters were born, and then to the UK.

> shame, it is a shame really, because that's the way people perceive other people. But if, you, you know, are white and well dressed right away they think, you know, she's educated (12, Britain, int 1, p.12-13).

This account draws attention to the ways unchallenged assumptions about women and people of colour result in her observation that 'people don't give you credit'. Such assumptions, she observes, can disadvantage some while creating conditions of privilege for others.

Numerous other examples illustrating the intersectionality of the processes of locating oneself and being located by others were evident. That is, a number of participants commented that in addition to being viewed differently because of their migration status and their physical features, they were treated differently because they were women, were poor and/or were single parents.

Here a mother expresses concern that her daughters may feel less valuable because they do not have the same material goods as other teens in the neighbourhood.

> Mother – I tell them (my daughters) tell people that it's better to learn, um, richer in the heart, not richer in the outside and which is not the important thing. I think, uh, your education is the most valuable so you need to study and get better knowledge (45, Canada, int 1, p.34).

This mother's strategy was to redefine what she saw as the prevailing view. A number of teen participants, particularly in Canada, commented upon the way lack of money for current fashion, or activities, made them stand out as different from many other Canadian teens.

Participants indicated it was the notion of being 'different' and the associated assumptions that shaped others' responses to them. In the following account a mother links a teen's immigrant status with her vulnerability.

> Mother - ...she used to play with (name of girl), she was a very lovely girl, now she has a baby, she left school, she left everything...
>
> res – So, these are worries for you? You think here's a nice girl, nice family, how did she end up in this situation?
>
> Mother – But, she was an immigrant (02, Britain, int. 1, p. 34).

In effect, she's saying, coming from a nice family isn't enough. If you're an immigrant, the cards are stacked against you.

While many participants, particularly in Canada, commented that their facility at languages was viewed as an asset in the workforce for others their accents, their foreign work experience or their newness to the country made them stand apart. Even when teens were

completely fluent in English and largely educated in their new country, their physical features or names often 'spoke' first and set them apart as 'different'.

Simply being teenagers meant they were made to feel unwelcome or a 'problem'. It has been argued that teens are viewed in popular culture and in policy as a socially challenging, often negative category, and are subject to a 'planned' exclusion from full participation in society. On this basis Prout (1999) argued teens in Britain meet the criteria as a case of social exclusion. The prevailing approach to teens has been to assign them a 'place' and to monitor them rather than encouraging them to become a part of the broader community enterprise.

The accounts provide insight into the ways visibility – race, gender, and poverty intersect to call into question individuals' value. In the above examples participants' responses can be seen as adaptive. That is, they do not challenge the prevailing view. They attempt to 'play within the rules' by becoming better educated, or by redefining the meaning of the situation. These approaches notwithstanding, the data suggest the persistence of such messages prompted some to question the basic premises of society.

In what follows I examine more closely the nature and impact of these messages of difference that contributed to the experience of being on the margins and their responses to them.

Resisting Categorization: Challenging Tacit Assumptions

As the accounts above suggest, some mothers had intentional strategies for preparing their daughters to define their place within broader society. One strategy was to advocate. A second was to ensure children knew their rights as citizens. A third was, through education, to acquire capital recognized to be of value.

Other approaches to challenging such categorizations were also manifest in the data. One of the key informants I interviewed in London was an immigrant woman of colour and a front line professional working with the communities of interest. When I interviewed her, her first comments related to the frequency with which she had to deal with the, often negative, assumptions held by others.

> "When people look at me they see me as a Black person and then make assumptions, that I am not English, not educated" (Field Notes, London, March, 01).

She is therefore attentive to how she uses language and seeks to ensure that people are made aware of her credentials, notably that she was educated in Britain and has extensive professional experience. In the context of the interview however, she indicated that to

accomplish this without erasing her heritage, which she views as a resource, requires ongoing dialogue.

This woman demonstrates awareness of the processes of categorization but she challenges assumptions others hold about her and seeks to redefine for them the nature of her capital. Her interview provided an example of someone who has negotiated entry to different contexts, the cultural community and the broader community of professional health care providers.

At the outset of our interview this Health Visitor challenged me to put forward my assumptions. She asked me:

> "Why did you choose me and not another Health Visitor? Why do you think my experience will be different to that of (an)other Health Visitor(s)?" (Britain, Key Informant (KI), 4, March, 01).

I had assumed that as a woman of colour she would likely have had a different experience in her working role than other Health Visitors and that she might also have insights into the challenges faced by immigrant clients and could speak about how she dealt with these in her role. I did interview other Health Visitors as key informants. They were not women of colour and did not raise these issues.

This Health Visitor illustrated ways in which her experiences, her colour and her cultural knowledge were resources she drew upon in enacting her clinical role. She spoke of ways she introduced these stocks of knowledge into her discussions with colleagues. As such, her position within the discipline provided an avenue for introducing alternative viewpoints. She gave examples of situations where her knowledge and her relationships with clients enabled her to challenge assumptions and preconceptions held by other professionals and to introduce alternative explanations for situations clients faced. Such actions can be seen as helping to dissemble stereotypes as well as taking steps towards introducing the value of different forms of capital (knowledge and expertise) into the practitioners' discourse.

If we draw upon the image of bounded or intersecting networks introduced in the preceding chapter, the Health Visitor can be seen as an agent positioned to facilitate access to another, in this case, professional network. The following example illustrates how she was able to use her position to enable a young mother to gain access to the resources of the formal network, resources for which she was eligible but being denied.

> "On one of her days off this Health Visitor was shopping and a woman of colour, who was one of her clients, approached her and asked for her assistance. The woman had a voucher she wanted to use to purchase

nappies. The clerk would not approve the purchase until the Health Visitor intervened on the woman's behalf noting, with authority, nappies were a legitimate purchase. In recounting the incident the Health Visitor indicated it was a small example of the ways people (in positions of power) make life difficult for immigrants and people of colour and in so doing also call into question their honesty, their eligibility for services while also making them feel like they are 'taking more than they deserve'. She also spoke of the toll

> she observes such assertions make on people's sense of self because they continually call into question people's own views of themselves (Field Notes, Key Informant, 4 Britain, March, 01).

In addition to helping her colleagues understand she also worked to make the resources of the formal system more accessible to, and relevant for, clients. By challenging people to justify or revisit their assumptions she can be seen as a professional resource within the formal system and played a role in challenging stereotypes that interfered with the establishment of relationships and the accessibility of resources.

Advocating for clients was a topic raised by other key informants as were concerns about the challenges of engaging with the ethnic community. Such challenges included working through the organizational changes taking place within the formal system, ensuring immigrants were aware of their rights and dealing with the lack of resources available for immigrant clients. In discussing the nature of community based interventions another Health Visitor commented that perhaps some of the initiatives, such as community arts programmes or community recreation programmes, were ideas of 'middle-class professionals' and would therefore, not be of interest to these poorer communities or missed when their funding was cut (KI 6 - Field Notes, Britain, Oct 2001).

While such a comment could be interpreted as being sensitive to a community's priorities, on further discussion it became evident that it was based on a perception of culturally defined class differences and as such illustrated some of the challenges the first Health Visitor had described she faced.

Teens also commented upon the differential treatment accorded people of colour. Being represented in ways that were problematic prompted teens to engage in reflection. Some reflected on the 'truth' of the representations and some proceeded to challenge what they viewed as misrepresentations in an effort to redress what they viewed as an injustice. Calling attention to perceived injustices however, did not always result in positive outcomes. A teen in London recounted her attempts to defend a classmate who was also an immigrant. In our interview she describes the teen as the "brainiest girl of the whole year".

> Teen – I wish I was her, she is so brainy and people here will pick on her. Like they will – they call her names. But for me it's, why pick on a girl that goes, is trying to do what she wants to do?...I nearly got in a fight for sticking up for her" (02, Britain, int. 1, p. 40).

This example illustrates the types of contradictory messages immigrants can receive. Succeeding at school is a prerequisite for success. Yet, your social history can justify exclusion.

Unlike this teen the Health Visitor was able to draw upon the capital accorded her through her professional credentials and role. These contrasts draw attention to the value of having 'institutional' backing when undertaking such forms of challenge.

The Health Visitor also had reflected on her situation and the challenges she faced. Such difficulties were related to categorical representations and the assumptions that informed them. She did not view this as something she was responsible for, rather that she, like many others, was systematically viewed differently in a number of contexts. She had an intentional strategy for repositioning herself and for drawing attention to assumptions underlying many taken for granted ways of interacting.

There were other examples of participants who sought to challenge different forms of inequities. One was the teen who urged her mother to change jobs because, in the daughter's view, the mother was being exploited. Another teen recounted how a group of students acting together sought assistance in dealing with an identified problem. They used the formal mechanisms within the school to change the situation by seeking to present their case to, and mobilize support from, the head teacher. It is unclear how involved the teen I interviewed was in this particular initiative, but by recounting the incident we see that her classmates' actions validated her own experiences in the classroom. Such initiatives help individuals to gain insight into the ways their experiences are influenced by broader social processes and others' actions.

The contrasts in experience illustrate Smith's (1990, 1987) contention that individuals' experiences are, to a great extent, shaped and organized by often unacknowledged institutional practices. For many of the study participants, experiences of marginalization are echoed in their observations of others. When institutional support is lacking participants conclude, their issues, and by extension, they themselves, are not important.

What is also evident is that speaking with 'authority' enables advocacy and such authority comes in different forms. As illustrated in Chapter Four, participants in this study spoke of the role voluntary organizations could play as resources for health care providers. Such resources, they observed, were largely untapped and generally unrecognized by

professionals in part because of structural constraints. It is also possible that such voices are not heard because they are not deemed to be relevant to the mission or objectives of the health care system or are not accorded the legitimacy someone with more formal authority holds.

The Experience of 'Being on the Margins'

These accounts draw attention to the importance of gaining access to new fields and being seen as having capital of value, to be seen as a person of value to move beyond being seen as a 'second citizen'. Gaining access to 'good' work roles was particularly important. For many participants feeling undervalued was compounded by the temporariness of their employment tenure. Rodriques (2002) documented a link between temporary employment and poorer health status for workers in the UK and Germany. A key issue identified in his research was the uncertainty temporary employment creates. The experience of marginalization can be seen as stemming from being categorized and viewed as a 'foreigner' or 'refugee'. Hearing such comments in their day to day dealings led participants to see themselves as 'not welcome'or, as welcome but only with caveats, to take on particular roles in society.

It is against such images that individuals must present themselves. As the teen in a preceding chapter notes, at her school, youth were categorised in various ways including as 'Hongers', 'white' or Canadian and it was within the context of such local images that she was attempting to locate and define herself. Yet, while others were 'placing' her, she was engaged in her own quest of finding a place and establishing an identity for herself. In this case the teen was able to draw upon her social capital to navigate new spaces and in some instances, challenge images.

While some participants received positive recognition for - their interests, community work, accomplishments at school, or talents at music or sports, for others, the categories that spoke most loudly were immigrant, refugee, or poor, each of which was associated with negative connotations.

In some contexts participants were able to translate such images into assets or capital which in turn enabled them to garner recognition. The shifting nature of the value of a particular asset was also evident in the participants' accounts. As a Canadian teen noted, those who were 'Chinesey' like herself, were more likely to be in the enriched or honors class and as such, received recognition within the school. Such success also had the potential to accrue criticism from other forums for taking awards or University seats, away from (white) Canadians.

As teenagers they are engaged in defining themselves as individuals, and family members, as well as trying to locate themselves within the context of their communities. It is clear however, that this process must take into account how others' views of them are presented and enacted. While teens set out to become part of diverse friendship groups for a number of reasons they may be excluded.

> Teen - yeah, and everyone kind of fits in, like I said, I think my school is pretty good in that way...Everybody thinks they're the popular people, so it's good (33, interview 2, Canada, pp. 30-34).

This teen is fortunate, she holds capital of value among her friends and feels she can influence her friends in positive ways. She argues she isn't succumbing to peer pressure and is in control of where she 'draws the line'.

> "....you can control what you do. Like some of my friends smoke, they're all around me, they're all smoking, so I don't smoke, I don't have to, you know in fact, I have good friends, like the ones I pick are like, oh, one time I'm like, oh give me a cigarette, I wanted to put it out, you know, because I try to get them all to quit" (33, int. 2, Canada, pp. 34).

Another teen indicated that living in London was "okay now", because she had gone to school here and had friends here, but she didn't like it. Part of the problem was a persistent sense that she didn't belong.

> Teen - It's very difficult to come from another country to come here, you see lots of different things, of course, maybe the parents, the grown ups it's not very difficult for them, but for young children, for example, my brothers, they really don't know where they're from...they've been raised here but the culture is different. So they don't know where they're from, we miss our culture, and, yeah, I think we need...You don't really belong because you're, I don't remember anything about my country and I'm not English because I wasn't born here, English is not my first language and so I don't belong to any of those, I'm in the middle" (04, int. 2, Britain, p.9).

When asked if she thought some of her experiences might be like those of immigrants from other countries she responded:

> " No, because I don't know what they're feeling, I don't know their culture, I don't know if they like this country or not, I just see lots of people from different countries that I don't really know" (04, interview 2, Britain, p.9).

As she describes it, despite having attended school in Britain and learned English, she hasn't been able to establish connections with others. The message she hears is that her history sets

her apart. This teen's comments also draw attention to the ways, by not being valued, an individual's social history is effectively erased or discounted with the effect, 'they don't know where they're from' and 'you don't really belong'.

This teen's perspective stands somewhat in contrast to comments made by a number of participants in Canada. Such participants noted that "Canada is multicultural", "Canada is a land of immigrants" and as such they saw themselves as part of the fabric of Canadian society. For participants holding this view, the perception that they were not alone and that their place was one for which there was a historical precedent seemed reassuring.

A number of participants discussed their experiences of marginalization using the language of racism. One teen thinks everyone has a responsibility for making Britain an inclusive society.

> Teen – I think in order to be able to live here, to get along, you have to be, you have, you learn the language first and get that out of the way and, uh, because, how do I put it? Um, like you have to be aware of the different, a lot of different things such as racism, for example, exclusion.
>
> res - How do you deal with that racism?
>
> Teen - Well, I don't think I get that much because I hang around with different people from different cultures and it's not so bad…I think it depends on you, on who you are. I mean if you're a racist yourself, I mean what are you going to do? So, I think that really depends on you and the sort of person you are…I mean at the end of the day we're multi-like we live in a multiracial society so…(01, Britain, int. 1, p. 19-21).

The importance of formal opportunities to participate in society is evident in the following account.

> "People must, um, try to integrate or participate more in, in the country when you are a refugee, yes, and use, use the rights that the governments (in a democracy) offers to the people. But, to be in that condition is like, uh *to be in a, um, a house that is not yours*" (04, Britain, int. 1, p. 31).
>
> "Yeah, *that is not yours and you feel, always you feel underestimated*" (04, Britain, int. 1, p. 32).

This participant acknowledges that in a democracy there are formal mechanisms for participation. Being portrayed by others in ways that do not resonate with their own views of self and hearing contradictory messages about their place contribute to the experience of being on the margins and of feeling continually underestimated.

Reflections on the Experience of Marginalization

Marginalization is characterized by a sense of inbetweenness as well as a sense of being overlooked, categorized or misrepresented. Marginalization is a process that has many forms and can be enacted in many contexts. The mothers and daughters involved in this research were engaged in a complex process of change. What is at issue is their desire to have a say in what place, or social location they will take up or assume and, for some, challenging or resisting how they are portrayed.

Marginalization has an impact on the fields to which participants were able to gain entry and it also influenced how they felt. For example, when a person's concerns or viewpoint were 'invisible', when capital or a contribution went unrecognized, particularly by persons in authority, individuals began to question the legitimacy of their feelings, the value of their abilities, or to devalue their own uniqueness. Also when mothers and teens discovered the 'rules' of eligibility – of friendship, of employment, of neighbourhood – may exclude them or limit their choices on the basis of illfounded assumptions they felt discouraged and sometimes angry.

Theoretical Positions on the Consequences of Marginalization

A number of theorists have noted that such forms of perceived disadvantage are cumulative and intersecting and accrue consequences. For example, this sense of being placed by others which is often attributed to 'cultural' difference, has been discussed by bhabha (1994) in relation to the place of women in society.

In his writing bhabha argues for the recognition of intersectionality and the need for societies to identify a sense of common purpose, and associated possibilities for engagement that cross what are often viewed as discrete boundaries. Moreover he suggests that a 'cultural' identity is not necessarily discrete and experienced the same way by people of similar heritage. In this study, while marginalization is in some contexts experienced as raced, participants may have also been excluded because of migration status, gender, age or social standing. As such, their experiences underscore the view that one's place, or value, is a socially constructed phenomenon.

These processes of categorization against which bhabha writes, assign people identities, roles, and 'places' that may both challenge and undermine their sense of self (bhabha, 1994). The participants' comments illustrate how seeing themselves 'represented' in public voices or domains as 'problems' rather than as resources, or, when they cannot

identify a place or context where their views are represented, theirs is an experience of marginalization.

Smith's view (1987a,b; 1990) recognizes such experiences but also focuses attention on the social processes that contribute to the experience. Following from Smith marginalization and accompanying feelings of invalidation, though experienced by individuals, are socially organized. The experience accrues to 'minority' groups from the ways social rules of settings such as work places, schools and neighbourhoods are enacted. In Smith's view those in the minority are persons whose viewpoint or perspective are not reflected in the premises upon which such settings are organized.

Reay (1999) notes that this issue of location and the role of capital in assigning value to it is discussed by Bourdieu. She observes that his concept of social space is underpinned by a multidimensional distribution of power in the form of different types of capital (cultural, economic, symbolic and social) underlying social positions (Reay, 1999, p. 2). It is important to note here however, that the value of different forms of capital are institutionalized through tacit agreement.

> Bourdieu's "concept of *habitus* permits an analysis of social inequality which is not simply dependent upon fixed notions of economic and social location. At the centre of this concept are the social practices which are the outcomes of an interaction between an individual, *habitus,* and field" (Reay, 1998b, p. 59).

How capital is deployed is shaped by the social contexts the individual has access to. The participants observed that they were often constrained by context, social rules, or others' expectations. They nonetheless sought to acquire the competencies needed to be a part of, and to gain access to resources of, the broader communities. Some were particularly successful at this while others were limited by the inaccessibility of different forums for acquiring capital.

Bourdieu alerts us to the insidious nature of marginalizing practices. "When marginalization becomes part of the *order of things,* it deprives one even of the consciousness of exclusion" (Bourdieu et al, 1999, p. 153). In such situations individuals are ready to accept their circumstances as immutable, as understandable, as logical. He provides examples of situations where individuals may not only accept the situation but may also be ready to claim responsibility for it. This then, for our purposes, represents a worst case, a situation where the case of exclusion is accepted as one's fate and the broader institutional practices enforce this view.

At issue is the interplay of imagery - and associated categorizations - evident in interactions with others that is also taken up in broader institutional practices. Processes, policies and rules may serve as continual reminders to persons, like those in this study, that they are different or perhaps not eligible. Participants spoke of being treated as 'cases' or 'files' rather than as people with strengths or attributes. These are socially organized experiences.

Both Bourdieu and Smith develop their analyses from particular cases because such accounts introduce us to the complexities of navigating social spaces. However, despite the relatively small number of cases included in this study, the participants' experiences resonate with observations of other researchers.

For example, Stack's (1974) groundbreaking analysis of impoverished communities in the US provided early insights into the important role played by social networks. Her work showed that within such communities everyday survival frequently depends upon connections with kin and friends in similar situations. However, this strength can also be a limitation if the network boundaries are closed. That is, if they constrain individuals' abilities to step outside of the network in order to gain access to a broader range of choices or opportunities.

Generally, the mothers and daughters in this study did not define themselves as part of a bounded social network. Rather, they spoke of having some, often limited, connections with persons familiar with their cultural heritage, and of striving to establish connections within the broader community. From their viewpoint it was the broader community that limited their access.

Researchers in the US have examined minority youth and their relationships within poor communities (Sullivan, 1989; Fernandez-Kelly, 1995). These researchers illustrated the local benefits to be derived from dense community networks, but also the ways access to work is network mediated. This was deemed problematic if adults (or peers) were not able to facilitate youths' access to work roles within the community or to gain entry to such roles outside. Additionally Fernandez-Kelly (1995) contends that in bounded communities adolescent pregnancy can be an attempt on the youth's part to achieve adult status, particularly when other options are not viewed as accessible. Such analysts draw attention to the benefits that can accrue from community networks, but also point to the value of being able to access resources (capital) outside of networks defined by ethnicity or neighbourhood. When teens have less capital to draw upon they are limited in what they can bring forward when establishing relationships with others thereby making it difficult to navigate entry to new fields.

In Portes' (1998) view Bourdieu's perspective adds depth to the work of social network theorists by illustrating how individuals can both benefit from, and be limited by, community characteristics and by drawing attention to the ways community features can limit individuals' abilities to access social capital. That is, if access to social capital is network mediated it makes it distinct from cultural and economic capital. Such a view also directs us to move beyond the view of social networks as 'sources of support' to examine the ways networks can contribute to exclusion. Taking this further, while impoverished and bounded networks may be 'rich' in cultural capital (i.e. they contribute to the creation of a sense of belonging and foster identity) they are not necessarily positioned to define individuals' social capital as holding value in fields outside of the social network.

So, when teens talk about not having a future or express despair about being able to step outside of their current situation, this may be a reflection of this phenomenon. Such teens may not have seen others do so successfully and /or may conclude that to be successful 'outside' one must relinquish the sense of belonging or identity offered by the neighbourhood, family or peer network. Such imagery aligns with the teen dilemma expressed above, that of, trying to reconcile one's place. Some teens were successful in maintaining links with their families and their cultural heritage while also moving towards gaining entry in roles within the broader community while others saw this as an either-or situation.

Researchers have documented that teens who have not completed school, or who are having difficulty in school are more likely to have poorer health profiles (Power, Manor, Fox, 1991; Power, et al, 1997; West & Sweeting, 1996; West, 1999) and are, in effect, more vulnerable. This analysis offers some insight into school as a site to acquire the tools, or competencies, needed to gain entry to new fields, a site of failure or a context that can potentially undermine the teen's sense of self, sense of place and sense of competency.

Towards Inclusion: A Theoretical Position

The data gathered in this study introduce us to the types of struggles and challenges that some must reconcile on a daily basis. Challenges that arise out of governing ideologies; ideologies of exclusion, ideologies premised upon othering that undermine possibilities for choice. While youth may ascribe to particular characterisations of the self but they must navigate a system that may continually challenge their views.

The processes of seeking voice and engaging in dialogue were evident not only in the boundaries between family and community they were also evident within the family discourse. Teens engaged with their mothers dissembling and reassembling images of

family, gender, community, work places and possibilities for their futures. Such discussions, often emotional, brought into the family domain the realities (as experienced by both mothers and daughters) of the constraints and opportunities of the broader societal context. These issues were examined through family discussions and made visible and often called into question *habitus* or, what were generally taken for granted expectations of families.

bhabha (1994) argues that there cannot be a solitary viewpoint on issues but rather an intersubjective one. It is therefore through engagement - challenge with (an)other - that agency is enacted. In bhabha's view the 'subject' is not a passive recipient but rather participates in redefining his or her place and history. In theory, engagement may be undertaken by individuals through collective action or dialogue.

For the participants in this study, the route to introducing alternative voices was at the 'local' level through dialogue where a number of points of view are put forward and discussed. It is important to note that dialogue implies mutuality and not the imposition of one view 'on' others. This conceptualization also implies a different view of authority. That is, it lends credence to differing viewpoints, and gives credit to different forms of expertise, rather than assigning authority solely on the basis of formal credentials or positional power. In the broadest sense formal organizations had difficulty accepting alternative views as was illustrated in the case of the mental health consultations one participant was involved in. But in the local sense similar difficulties were in evidence. Families, for instance, had their own structures or traditions in many instances had great difficulty accommodating teens' challenges to *habitus*.

Building from bhabha's perspective to Smith's (1990) it can be argued that 'official' or 'taken for granted' perspectives are not shared by all and when this is not recognized in the way structures are organized or policies enacted, societies, or social organizations within societies, can systematically exclude or, eclipse minority, or alternative views.

On this point Bourdieu and Smith's perspectives differ from Giddens' (1984, 1991, 1993) stance that structures do not constrain. But, as I read Giddens, this is because it is his view that social structures (and associated institutional processes and policies) are meant to provide the 'ideal' framework, or to set the agreed upon standard that all should strive toward. This view assigns structure the role of sustaining the status quo and presumes the agent chooses to play by the rules, or not. But, it is important to ask, whose views are reflected in the 'standard'? Are there groups in society that benefit to a greater (or lesser) degree from the status quo? And, perhaps more importantly, is it a simple matter of 'choice' to take up the challenge to fit in?

As accounts are examined experiences of oppression and the associated processes of marginalization, with their attendant effects are revealed. The participants, while seeking to establish connections and become a part of the community, often feel they must step away from their personal histories and ways of being in order to take a place in these new societies.

The examination of accounts that focus on the interface between individuals and families and the interface between families and communities draws attention to divergent perspectives, but also shows ways these points of interface can provide opportunities for engagement. Further, they demonstrate that engagement towards change is not unidirectional but reciprocal and illustrate why a commitment to exploring different perspectives must be made and acted upon at all levels.

Marginalization, as represented in the literature and from the participants' accounts, is characterized by being 'assigned' a place, and by being outside of, or excluded from, processes where decisions are made. It is such processes that lead to exclusion or conversely foster inclusion.

Exclusion takes different forms. One is the creation of criteria for inclusion through processes of credentialing which effectively 'screen' people out. While there are often explicit criteria, there are also frequently implicit criteria in operation that define the forms of expertise that will be recognized as local and in doing so may limit participation.

Or, when there are no formal mechanisms for inviting participation, exclusion results. For example, while schools may espouse a philosophy of family involvement, by parents' accounts, they are effectively excluded from high schools because the environment provides limited opportunities to meet with teachers or other parents or to participate in discussions about school programmes, resources or supports for learning.

Similarly, while health care may espouse a philosophy of partnership and participation, teens do not recognize a health mandate within their schools and with few exceptions teens and mothers viewed health services as illness based services accessed via their GP. In both instances although the door is theoretically open, there were no invitations to enter.

Lack of economic or material resources can also create barriers to participation. Numerous examples of situations where teens could not pursue interests because they could not afford the fees for participation are in the data. Other participants, particularly mothers but in some instances teens, noted they could not participate in activities because they had commitments to the family (such as childcare). While some of the participants excelled at school and the school therefore became a forum within which they received recognition, for many of the participants, school provided ongoing challenges, socially and academically for

which they felt they received little support. Such teens were therefore looking for recognition in other forums and, because options were so limited, this became a source of worry and concern for many parents.

As Bourdieu observed, the challenge of gaining entry to social or interest groups is particularly problematic for those who are children of immigrants because of their "*negative symbolic capital,* linked to the external signs" (Bourdieu et al, 1999, p. 185). His comments about the experience of youth in France resonate with the stories heard from many of this study's participants.

> "What is at the heart of these adolescents' experiences: the feeling of being tied to a degrading ("rotten") place by lack of money and transportation ... or, more simply, a stigmata that blocks access to work, to leisure activities, and to consumer goods, etc.; and, more profoundly, the inexorably repeated experience of failure, first in school, then in the labor market, which prevents or discourages any reasonable hope for the future" (Bourdieu et al, 1999, p. 185).

As these study data suggest, and as Bourdieu and colleagues (Bourdieu, et al, 1999) have also observed, parents of such teens are often not in a position to act as resources. In part because they too are isolated but also because of the social location to which they have been assigned.

Does Marginalization have an Impact upon Health?

Is there evidence that these practices, these experiences of marginalization, have consequences for health? Williams and Williams-Morris (2000) undertook a comprehensive review of research, primarily undertaken in the US, in order to gain insight into the ways racism, one basis for marginalization, can impact negatively on mental health. Upon reviewing fifteen population based studies that measured links between discrimination and health they concluded racism, measured in a number of ways, was associated with high rates of stress, depression and psychological distress. In addition, some studies documented changes in such physical health parameters as elevated blood pressure.

> These authors concluded there were three routes to poorer mental health. "First, institutional discrimination can restrict socioeconomic mobility. This has led to racial differences in socioeconomic status (SES) and exposure to poor living conditions that can adversely affect mental health. Second, experiences of discrimination are a source of stress that can adversely affect mental health. Finally, the acceptance of the stigma of inferiority on the part

> of some minority group members can lead to impaired psychological functioning" (Williams and Williams-Morris, 2000, p. 243).

They base their first point on research that shows that in the US Blacks are more likely to be poor, women are more likely to earn less money and overall more likely to live in poorer neighbourhoods. They therefore contend it is "the concentration of poverty and not racial segregation *per se*" (p. 247) that is the critical determinant. This conclusion would support the view that the social organization of the community can influence individuals' abilities to access social capital.

Williams and Williams-Morris (2000) also argued that the evidence demonstrated that "racial segregation has also let to unequal access for most blacks to a broad range of services provided by municipal authorities" (p. 248). In such neighbourhoods the research they drew upon documented exposure to higher rates of violence, crowding, noise and population turnover. These factors are related to adverse health independent of SES.

Their conclusion that 'acceptance of the stigma of inferiority' is one consequence of racism was derived from a number of studies that documented an association between internalized racism and alchohol consumption (Taylor & Jackson, 1990), lower self esteem, less ego identity (McCorkle, 1991) and depression (Tomes, Brown, Semenya & Simpson, 1990). They propose that in such racialized environments individuals accept popularized, stereotypical, negative images. Williams and Williams-Morris (2000) argue that in the US stereotypical images have persisted in part because the general view of Blacks as inferior has not been systematically challenged. Their work builds from research that has refuted theories of genetic superiority of whites and brings together a body of research that draws attention to associations between racism as a feature of societal interactions and health.

I introduce these authors' work here because it draws attention to the potential significance of the participants' accounts of their struggles against processes of social location. Processes that challenge their view of self and that assign them to the margins. As these women work through the question "Where do I belong?" they draw upon their experiences and what they observe happening around them. While some teens see leeway in how they define themselves and this process is fostered when they have successfully accessed new fields, one where entry is not defined by ethnicity, material means or gender. Teens who view the family cultural capital as negative and their opportunities for a place outside of the family or neighbourhood network as limited would, from Bourdieu's conceptualization, be more vulnerable, more likely to face a life of exclusion. Williams and Williams-Norris' work documents a similar pattern.

The question remains however, are these issues of concern to, and for, health? In the ıext chapter I discuss the analysis of the data gathered in this study in relation to the heoretical premises of British and Canadian health policy discourse.

ɔummary

This chapter examines marginalization and its effect, exclusion from the viewpoint of he study participants. Marginalization is a lived reality that has consequences for how day o day decisions are made and how interactions are structured. Marginalization also has an ɛffect upon the ways individuals see themselves as persons and can convey the message 'you don't belong' or 'you are not a person of value'. Such messages contribute to a negative view ɔf the self. But, marginalization also places limits on the nature of relationships individuals ɛan establish with others and contributes to a sense of invalidation. In this chapter, theory was drawn upon to analyse the participants' accounts and to identify ways in which marginalizing practices are experienced and sustained through the social organization of ɔociety. The analysis considers ways individuals challenged marginalization, although not always with desired effects.

Gaining access to such accounts and perspectives means that these are now available as evidence that there are issues to be dealt with. Such insights prompt us to consider if the ways in which the issues faced by immigrants and refugees have been conceptualized within health literature have had an influence on how issues of culture and health have been taken up. These questions are considered in the chapter that follows.

Chapter 7

Health Inequalities from an'Other' Perspective

Discussion and Implications

In this chapter the analysis presented in the preceding chapters is discussed in relation to British and Canadian health policy discourses. In introducing the theoretical and methodological premises of this study I noted that policy documents and the ideologies that underpin them are texts of relevance to the study analysis. In this chapter I focus on the central concepts identified in the study participants' accounts and proceed to explore the ways these are taken up in policy discourse.

This analysis compares policy premises with the experiences of the first generation immigrant mothers and daughters who participated in this research. In this way, the assumptions inherent in the formal policy documents sampled are 'evaluated'.

Merging Analytic Perspectives: Towards Policies of Inclusion

At this point in the study two perspectives are brought together. The participants' perspectives, as reflected in the concepts central to their experience, are examined in relation to theoretical perspectives that underpin policy. The concepts central to the participants' experiences are broadly related to experiences of marginalization and exclusion that permeate a range of day to day experiences. The theoretical perspectives that have informed policy, or are part of the current policy discourse, that will be considered here have been previously discussed under the general rubric of explanatory perspectives on inequalities in health.

In what follows I examine four areas. First, I summarize the key theoretical perspectives on health inequalities to be considered in this chapter and consider with which explanations the study participants' experiences align. I then describe the policy stance taken in Britain and Canada and consider what additional, or alternative, perspectives this study suggests. Finally, I draw upon these insights to introduce new considerations for the policy discourse.

Perspectives on Health Inequalities

The main explanations for health inequalities, and the nature of evidence to support them, were introduced in Chapter Two. The explanations that will be considered here are ones for which this study offers new insights. These include: the *social structural explanation,* and research related to it that has sought to gain an understanding of the key elements of the social environment that have an impact on health. This includes how poverty influences

health but also characteristics of peoples', particularly women and children's living and working environments (Annandale & Hunt, 2000; Gilmore et al, 2002; Marmot et al, 1997) and the racializing practices of the broader society (Nazroo & Davey Smith, 2001; Williams, 1996; Williams & Williams-Morris, 2000) that influence health. I also consider perspectives on the *accessibility of health services* as conditions influencing health inequalities (Benzeval, 1999; Benzeval & Donald, 1999; Jacobson, 1999; Robinson & Elkan, 1996) and the *relative poverty* explanation (Wilkinson, 1994, 1996, 1999) and its underlying theoretical premises.

Social Structural Explanations for Health Inequalities

The evidence generated from the study participants' accounts aligns with several explanations of health inequalities. That is, as has been concluded by analysts taking a population health perspective, the explanations are not mutually exclusive but are intersecting.

Poor Material Circumstances

It was a premise of this study that women, particularly first generation immigrant women, living in *poor material circumstances* are among those who are likely to be 'at risk' for health inequalities. This study did not compare women living in poverty with women of means, nor was it designed to correlate health outcomes with living conditions or to contrast experiences of women of colour with other women's experiences. As I am working within the qualitative paradigm, I worked from the premise that one recruits a sample that can speak to the experience of interest. This study therefore, explored the nature of relationships first generation immigrant women with limited material resources established with others in the formal and informal system. I accepted the evidence that there are links between material circumstances and poorer health over the life course, particularly for women (Annandale & Hunt, 2000; Arber, 1997; Arber & Cooper, 2000; Graham, 1993) and persons of colour (Nazroo, 1999; Nazroo & Davey Smith, 2001;Shaw et al, 1999). I also accepted the evidence that relationships are resources for health. This study offers some additional points for consideration by those who are exploring the ways material circumstances influence health. A topic of debate by researchers undertaking such work relates to which measures are most accurate indicators of *individuals' social standing*, particularly for women (Britain, DoH, 1998a,b, Blaxter & Paterson, 1982; Higgs & Scambler, 1998; MacIntyre, 1997; Townsend & Davidson, 1992; Robinson & Elkan, 1996; Whitehead, 1992). A number of studies have taken the position that level of education is a better, more accurate, indicator of SES than income. However, although this is a small sample in statistical terms, because downward mobility was a significant feature of the post migration experience for these families,

researchers should not necessarily assume that level of education will translate into similar standards of living across all sectors of the population.

The level of education indicator also draws attention to issues of importance for teens. This research offers some insights into reasons why teens like those in this study may not achieve the same level of schooling as other population groups. Schools were central forums for acquiring capital but for a number of teens in this study school success was very tenuous. The environment of the school, and resources available there, were seen as having an important influence upon teens' experiences. When teens did not feel they were getting needed learning support, or when the school environment was experienced as unsafe due to bullying, or when a teen was the target of racist comments or violence, schools were not seen as resources.

Conversely, where the school environments offered opportunities to acquire a range of capital and to demonstrate competencies in a number of forums, not all linked to academic profiles, the teens usually spoke of school, and their experiences there, in positive terms. And, when teens did perform well academically and received recognition for it, and saw themselves as having a valued place in the school community they were encouraged to continue to invest in school.

Further, even though most parents were fervent in their desire for teens to invest in school many teens saw contradictions between what they were being told was needed to succeed and what they observed their parents or others were able to achieve. For a number of teens such contradictory messages were difficult to ignore particularly when coupled with experiences of marginalization.

These observations about school climate are important if we wish to address the links researchers have established between lower educational attainment, frequently as a consequence of exclusion, as associated with a greater likelihood of unemployment and poorer health over the life course (Power et al, 1997, 2002; West, 1988, 1999; West & Sweeting, 1996; Whitty, Aggleton,Grmarackow & Tyrer, 1999).

This study also offers insights into the documented links between characteristics of the work environment, the nature of individuals' control over their work, and health (Marmot et al, 1997; Gilmore, et al, 2002). These studies suggest that people who work in environments where they have some degree of control over their work, and receive recognition for their work in a number of ways, including higher wages, have better health profiles. Further to this others point out that access to different occupational roles is gender mediated (Annadale & Hunt, 2000),

The majority of participants in this study were in low paying, often entry level, positions and frequently had little control over their work. Many were not working in areas that matched their educational preparation because it was not recognized, or they had not re-qualified in their field, usually because such re-qualification required considerable time and money to undertake. Additionally, many participants worked in contexts in which interactions between persons in other roles were limited (i.e. cleaners who worked at night after other employees had left for the day). Also, worries about finances were ongoing. Such conditions, it has been noted, are associated with poorer health profiles.

There were cases in the data however that indicated that despite downward mobility it was possible to derive satisfaction and recognition from work roles. One example relates to experiences within the voluntary sector. These were voluntary work roles some individuals had created to address an identified need and roles that drew upon participants' interests and competencies. Another source of benefit was evident when a paid or unpaid work role offered opportunities to move outside of the generally limited social field.

These observations draw attention to the value of initiatives within the voluntary sector for individuals and for the community at large. They also suggest that structuring the work environment in ways that fosters interaction between work role categorizations may create 'communities' within working environments or could at least begin to dismantle categorizations of people as 'roles' - i.e. 'the cleaner', and in so doing contribute to changing pre-conceptions.

Racializing Practices & Health

I invited women to become involved in this study because they were immigrants who lived in areas of the city that have lower socio-economic profiles and because of studies that indicate there are more 'ethnic minorities' in the lower social strata. It was not my intent however, to measure their experiences against other families of limited material circumstances but rather to explore with participants the nature of their experiences in managing within the community. A number of scholars whose work has been cited here, have addressed issues of racialization and a few have drawn upon population based studies to make the case that racialization is associated with poorer health (Nazroo, 1999; Lillie Blanton & LaVeist, 1996; Williams & Williams-Morris, 2000).

In this study many participants, particularly in Britain, spoke about their experiences in language of marginalization and exclusion. While mothers spoke of the difficulties associated with being viewed as 'different' it was the teens' experiences that seemed to have qualitatively the greatest, negative impact. Being assigned to the margins, being overlooked

and criticised, bullied, abused or simply left out, for having a different social history created among the youth, who had these experiences, a sense of exclusion.

The analysis undertaken here draws attention to several aspects of such racializing practices. One is the *experience* of being on the margins, the second is the ways in which *access to opportunities* can be denied and a third is the ways in which such practices place limits upon social networks. Even though the accounts as presented in the preceding chapters do not represent marginalization solely as a consequence of racializing practices, there are aspects of this literature that offer insights for consideration

The impact of such experiences seems to have been keenly felt by the teens. Such observations are consistent with developmental theory that characterizes teens as actively engaged in consolidating their identities. Teens may therefore have fewer defenses against such forms of challenge. Such negative messages in this developmental stage, when they go unchallenged by others but particularly persons in authority, may be more likely to contribute to identities of self as 'other', versus self as a person of value or a person who is fully eligible to participate in broader society. A number of researchers suggest that such negative images could contribute to the development of health, particularly mental health, issues (Friere, 1993; Khanlou, Beiser, Cole, Freire, Hyman & Kilbride, 2002; Rogers, Adamson & McCarthy, 1997; Williams Williams-Morris, 2000).

Inequalities in Access to Health Services

An explanation for health inequalities that is receiving increased attention in research and policy relates to *inequalities in access* to health care services (Benzeval & Donald, 1999; Goddard & Smith, 2001). Benzeval (1999, 2000) has taken the position that among disadvantaged population groups there are health needs that are not being addressed. While it is not his central point Nazroo (1999) and others (Benzeval, 1997; 1999; Benzeval & Donald, 1999; Nazroo, 1999)have argued that for some groups within the 'ethnic minority' population in Britain racism and discrimination interfere with access to services. A variation on this explanation is the policy position and related research aimed at matching needs with services (Billings & Cowley, 1995; Cowley, et al, 2000a; Goddard & Smith, 2001) .

The participants in this present study generally viewed illness care as accessible via their GP. They also generally did not see poverty as a factor that contributed to illness, although there was one case where damp living conditions were linked by the mother to the development of asthma in a child. Rather, like participants in Blaxter's (1997) research, unless poverty or working conditions, interfered with their ability to purchase treatments (such as

medications) or take time off of work to go to the physician, the participants viewed poverty and illness as separate issues.

This notwithstanding, in this study a number of barriers to illness care were noted by the participants. These included language barriers. There was, for many, a need for interpreters or for materials or programmes to be organized or presented in ways that would ensure conditions interfering with patients receiving the same level of care would be addressed. Not addressing such barriers can result in poorer health outcomes by delaying diagnosis or interfering with the mobilisation of appropriate illness management resources (Nazroo, 1999; Lynam et al, 2003).

An example of this was raised by a number of participants who noted that there were groups among the population who were not likely to be using health promotion and illness screening programmes or resources to the same extent as the general population. Blaxter (1990.1997) suggests that people of lower SES are less likely to use prevention services. This study suggests that using different approaches to making health information available would be of value. One approach recommended was to draw upon the expertise of voluntary organizations in developing strategies for accessing communities. In addition, as none of the teens participating in this research were familiar with youth focussed health promotion resources available and as youth are at risk for particular health issues they should be consulted.

Social Cohesion, Integrated Networks & Health

It is perhaps in relation to the research that has established links between individuals' social networks and health that this study offers the most interesting insights. Research related to this perspective on health inequalities that was introduced in Chapter Two included the influential population based longitudinal study that correlated social support and integrated social networks with better health status (Berkman & Syme, 1979; Haan, Kaplan & Camacho, 1987) and documented that having social support was associated with resilience in vulnerable children (Werner,1989).

More recently Wilkinson (1994, 1996, 1999) analysed evidence from several countries throughout the world, including Canada and Britain, and argued it is not level of income but rather income differential that is important. Wilkinson's analysis shows that a narrow income differential within a country's population is associated with lower mortality rates. While this is interesting it is the premises underlying his conceptualization with which the data in this study align. The underlying tenet of Wilkinson's theory is that egalitarianism (of which income differential is presumed to be an indicator) is associated with social cohesion which, in turn, is associated with better health. His perspective builds from work of theorists

examining social trust (Kawachi et al, 1997), research on 'civic communities' in which communities with high social capital are characterised as communities with greater community involvement and lower income disparities (Putnam, 1993, 1995) and research that has shown violent crime is associated with greater income inequality (Hseih & Pugh, 1993). However, it is cohesion that appears to be the concept of particular relevance to this work.

> "The epidemiological evidence that more socially integrated individuals enjoy better health lends credibility to the view that social cohesion may mediate between income distribution and mortality on the societal scale" (Wilkinson, 1999, p. 73).

These observations are also supported by Marmot and colleagues' (Marmot, et al, 1997) analysis that a number of social conditions account for all variation in depression and psychological well being and half of the variation self rated health across the populations studied. The mediating factors identified in these studies were psychosocial characteristics of the work environment which included; the provision of the opportunity to use a variety of skills, job satisfaction, *social support* and control over work.

Similarly, Cooper and colleagues (Cooper, Arber, Fee & Ginn, 1999) identify social support and social capital as two concepts key to understanding links between social circumstances and individuals' and communities' health. They argue for a shift in emphasis in health promotion research from changing individual behaviour towards fostering change in neighbourhoods, communities or social systems.

While there were teens and mothers in this study who did feel a sense of connection within the ethnocultural communities and, for some, with the broader community the experiences of many participants in this research illustrate the converse. That is, they focus on what it is like to lack support and to feel isolated within, and excluded from, many aspects of community life. While being connected with the local community has positive effects Wilkinson's research draws attention to the need for connections outside of such network boundaries.

Wilkinson's research established links between social cohesion, as a feature of the broader community, and health. Social support would be the individual counterpart to social cohesion. This study, and the research cited above, suggest that it is not a single condition that explains variation, but rather that conditions are both intersecting and cumulative. Persons who feel supported feel that they belong, feel understood by those around them, and feel they can mobilise needed material resources to manage situations or stresses facing them.

By contrast, those participants in this study whose experiences were characterised by marginalisation repeatedly spoke of feeling alone, as if they did not belong, and as if they

were not part of the community enterprise, particularly when they attempted to navigate entry to new fields. Continually hearing the message that 'you are different' is inconsistent with messages of support that are generally premised upon an assumption of shared experience. Such individual messages are further compounded when the broader society conveys messages that support racializing practices, or exclude youth in general (Prout, 1999).

The analysis in Chapter Five illustrated participants' experiences of having limits placed on their access to potential networks thereby interfering with their ability to develop or mobilise resources and illustrated ways that being poor also constrained choices. It was also observed that teens lacking connections with individuals or programmes within the broader community were particularly vulnerable if they were facing difficulties at school and if they were at odds with their families. Such teens would not be appraised as having integrated networks of support and would therefore, in Wilkinson's view, be vulnerable.

In addition, the study participants were frequently viewed as not having any capital of value to offer in social exchanges. While lack of recognition can manifest itself as lack of support – lack of affirmation - the participants' accounts also suggest these influence how they view themselves. For example, many teens felt they were denied an opportunity to be 'themselves'. They were rather, expected to redefine or represent themselves as an'other' to minimize or mask their personal history and achieve what was frequently conditional acceptance into a group of peers, the classroom, the playground or neighbourhood. This form of lack of recognition of capital cuts to the core of an individual's identity and I would suggest is particularly troublesome when developmentally teens are engaged in a process of confirming their identity.

Teens' accounts of their language abilities provide another example of this process of assigning value to capital. In Canada teens were more likely to say that their first language was an asset. In Britain, language was generally viewed as a marker of difference. Canadian teens commented that having a different social history was not uncommon and such differences were part of the multicultural fabric of Canadian society. Teens in London were more likely to say they were not English and would never be (accepted as) English.

In addition, teens needed to reconcile contradictions. Teens saw others like themselves sentenced to poor jobs and poor neighbourhoods and were therefore not hopeful about their future. These observations resonate with Shaw and colleague's (1999) view of social exclusion.

> "The term 'social exclusion' also relates to cultural aspects of exclusion and discrimination and refers to the relationship between the included and

> excluded, the meaning and identity of the excluded" (Shaw et al, 1999, p. 222).

Implicit in these authors' comments is that differential and relational power of groups is manifest in intergroup relations and that material or social exclusion contributes to the 'experience' of exclusion. Shaw and colleagues like Bourdieu note the ways exclusion can limit access to different forms of capital.

> "Those who are more socially included have greater access to resources, not only in economic terms but also resources which come from living within a society – such as educational opportunities, social networks and support" (Shaw et al, 1999, p. 223).

To this point it has been argued that the criteria for access to resources assigning value to capital are socially defined. But what the preceding discussion also underscores is that social relationships are 'relational' and characterized by mutuality. The analysis presented here illustrates the ways that access to social relationships is mediated by social structural constraints. But it also draws attention to another possible consequence of marginalization. That is, if people feel they have no capital of value to offer in an exchange, they may limit their interactions.

Here then, it is argued that this study offers some additional insights into ways social conditions may contribute to inequalities in health. In what follows I examine ways unchallenged assumptions about individuals' competencies or capabilities are taken up in, and legitimated through discourse.

Does Policy Discourse make a Difference?

The theorists whose work has informed this study argue that discourses of official policy texts and the ideologies that underpin them exert influences on the ways issues are understood and addressed and these in turn are reflected in the ways social structures are created.

As the perspectives on health inequalities were examined in the preceding section, it was possible to make visible the ideological premises underlying particular perspectives. The policy perspective derived from each explanation embodies a particular set of assumptions about people, their relationships to broader society and in turn society's response to, or responsibility for, them. So when a government makes a decision about what policies to adopt, based on evidence available, they accept the inherent assumptions. But frequently the assumptions underpinning such perspectives are tacitly accepted without critical appraisal.

Smith and Bourdieu argue persons outside the policy process provide perspectives that may enable such a critical appraisal. Immigrant women and their daughters are one such group.

But, does the language of policy really make a difference? Traynor (1999) observes "discourses provide positions that can be adopted, spaces that can be occupied, categories that can be made available" (p. 27). He would therefore support the case that discourse does make a difference. Theorists whose work has been drawn upon here to illustrate the ways in which marginalization and exclusion are represented, or experienced and how such exclusionary practices are sustained, focus considerable attention on the impact of discourses of difference. Hall's (1990, 1996a, 1996b) work reviews the ways history has defined groups and cast them in particular roles through language and practices of 'othering' that are drawn upon in day to day conversation but also taken up in research and policy. bhabha (1994) writes of the experiential consequences of continually being misrepresented, or overlooked. They have traced ways changing discourses have influenced representations of, and assumptions about, people of colour.

As noted earlier, the teens in Britain were more likely to speak of their experiences using terms like racism, or exclusion and often, despite citizenship, referred to themselves as not 'British'. Whereas Canadian teens, while acknowledging difference, linked this to being 'Canadian'. These teens were also more likely to view some of their cultural features or abilities as assets. So too, the Canadian teens had access to a wider array of community based programmes, including programmes within their schools that enabled them to acquire new competencies and to move into different fields. It could be argued that such opportunities contributed to their own views of themselves as persons of value.

Following the direction of Smith and Bourdieu then, a central issue is that some policy discourses contribute to separating out - programmes, resources, individuals - while others foster a view and create structures that are (more) inclusive. Or, drawing upon Wilkinson's work, there are fewer health inequalities in societies where the discourses and the associated programmes and structures create the space for, and provide opportunities for, the creation of a more cohesive, socially integrated society.

What then are the features of policy discourse? In Canada *multiculturalism* with concommitant recognition and valuing of *diversity* are defining features of the Canadian political identity and have been so for several decades. As such, the norm in organizations is diversity, the standard to be met in providing care, or delivering education, is to recognize the whole, while *equity* and accessibility are central principles to be upheld in health care. Equity is to be enacted in ways that recognize individuals bring different resources, a view that is defined by some sources as vertical equity (Carr Hill, 1994; Robinson & Elkan, 1996).

This is not to say that there are not tensions, that there are not challenges to this view. For, there are individuals, groups and federal political parties who espouse a different stance and draw upon evidence to support it. There are others who argue, and FN are a case frequently drawn upon to illustrate this, that the policy climate still privileges some groups over others. But in the current policy, legal and political climate, when challenges become 'official' the default position organizations are held to is one of inclusion.

Britain also had an era of multiculturalism but rejected it as inadequate because it did not address the structural conditions underlying the differential status of ethnic groups (see for example, Culley, 1996; Walker, 1998; Walker & Walker, 1997). Similarly, while anti-racism prevailed in the 1980s it was deemed divisive because it interfered with dialogue and dichotomized the issues. At the time this study was being completed Britain entered a new policy era and made a commitment to redressing health inequalities and mitigating social exclusion. A key initiative was the establishment of the SEU. Also in this time period the government made a commitment to modernizing the public services and to redressing inequities faced by racialized groups (Britain, HO, 2000, March) and amended the Race Relations Act (Britain, HO, 2001,a,b,c,d). These initiatives suggest that the government is attentive to inequities and has put in place mechanisms to ensure they are at the centre of the policy agenda.

In response to the question, 'Does discourse matter?' The participants' experiences would suggest that yes, it does. Concepts of exclusion, minority and diversity have made their way into the day to day language of participants and these views have both intended and unintended consequences. For defining ourselves, or others, in negative terms has an effect – one which may be more keenly felt by youth. The prevalence of such rhetoric may bring an individual to ask: How can I come to see my self as a person of value, with a contribution to make if I am characterised as 'minor' and as excluded?

In the next section, I examine the current health policy discourses to prompt reflection on the messages from the participants in this research.

Shifting Discourses

Intersectoral Influences on Health Recognized in British Policy Discourse

Despite the considerable research that has documented the systemic nature of health inequalities and linked it to such social conditions as poverty, education, racializing practices and poor working conditions governments have not, historically, made a commitment to the restructuring and financing needed to address these issues. Policy initiatives undertaken in Britain in the last 4 years suggest a shift in the ideological premises underpinning the broader policy agenda. In what follows I trace the steps that have been taken that suggest the social

roots of health inequalities are being recognized. A number of the initiatives within health appear to have been influenced by initiatives of the SEU.

With a change of government from Conservative to Labour, a number of specific government sponsored initiatives have challenged conventional approaches to health policy and sought to place health inequalities at the forefront of the policy agenda in Britain (Britain, DoH,1998d; Britain, DoH, 2000a). As will be seen from the examination of policy initiatives that follows implicit in this government's recommendations is the intention to recognize the need for change in the social structures that have constrained socially excluded groups.

In 1997, at the start of its mandate, the Labour government commissioned two studies. One was an evaluation of the "Health of the Nation" policies that had guided health decision making and resource allocation between 1992 and 1997 (Britain, DoH, 1999, 6 July) and the second was an Independent Inquiry into Inequalities in Health chaired by Sir Donald Acheson whose report was published in 1998 (Britain,DoH 1998a,b).

The Health of the Nation policy sought to incorporate some of the WHO guidelines for health, set goals related to five categories of illness and made a number of recommendations regarding reoganization of health care services to facilitate implementation. The evaluation of this policy, undertaken by independent researchers and funded by the Department of Health took place between September 1997 and March 1998. They gathered data from selected Trusts throughout Britain, from front line workers and administrators and data related to changes in illness profiles in the selected categories. Their report (Britain, DoH, 1999, 6 July) concluded that the policy, as written, was viewed positively by stakeholders. The targets set were appropriate. The calls for more initiatives in illness prevention and for the establishment of alliances between sectors (formal and informal) of the health care system were viewed as positive steps.

They noted the implementation of the policy was difficult because more urgent issues took precedence, and no new funding was allocated to implement the recommendations. The impact on local policy and programme decisions was negligible.

Looking at some of the difficulties associated with the implementation of this policy through Bourdieu's theory points of difficulty can be identified. One issue identified in the evaluation was that while additional resources were allocated to provide illness care and targets were set as goals for the reduction in the incidence of such illnesses as heart disease, stroke, and cancer unless attention is paid to barriers to access it is possible that some sectors of the population will benefit to a greater extent than others, and without concurrent attention to broader issues, it is possible the conditions that create risk will persist.

So for example, in this present study it was learned immigrants may be facing illnesses unfamiliar to them. They therefore may be unfamiliar with warning signs or screening measures available to them and as a consequence not receive timely treatment. In the most recent policy documents, published since this study data were gathered, these concerns have been targeted (Britain, DoH, 2003, July). In addition, the most recent action plan recognizes that disadvantaged neighbourhoods may need additional resources in order to more quickly achieve health profiles of more advantaged communities (Britain, DoH, 1999, July; 2000a; 2003, July).

Prior to these most recent initiatives however, the Government's White Paper, "Our Healthier Nation" (Britain, DoH,1999) set out an action plan for addressing priority health issues. The action plan included initiatives to reduce mortality related to specific illnesses and initiatives designed to take social roots of health inequalities.

The policy acknowledges the links between individuals' health and their social environment and hence proposes to foster the creation of healthy neighbourhoods.

> "People relate closely to their neighbourhoods, and are likely to be healthier when they live in neighbourhoods where there is a sense of pride and belonging" (Britain, DoH, 1999, July, 4.34, p.52).

Proposed strategies for accomplishing these goals recognize "participation in arts and sport can promote social cohesion by building strong social networks" (p. 52). As well as developing a plan for renewal of neighbourhood facilities, an overriding goal is to build sustainable communities and recognize and build upon community expertise by involving the local community in project planning (Britain, DoH, 1999, July, 10.24, p. 127).

The language of this policy speaks to, and seeks to address, the experiences of the participants in this research and also takes up issues raised by other researchers in this era (Alexander, 1999). That is, it recognizes that marginalization and exclusion are experienced at the local level, in neighbourhoods, and that opportunities to develop capital are not readily available to those of limited means. The most recent policy initiative "Tackling Health Inequalities: A Programme for Action" (Britain, DoH, 2003, July) further elaborates on these initiatives and delineates in greater detail the nature of community based strategies for remedying structural inequities in service delivery.

The policy discourse in this new era makes visible commitments to redressing inequities and proposes to do so in part by working in partnership with community and voluntary organizations while also building community capacity (DoH, 2003, July). The premises of this policy era align with my understanding of the ideologies underpinning the work of key researchers in health inequalities. It seeks to foster social cohesion (Wilkinson,

1996,1999) address inequalities in health experienced by ethnic communities through structural change (Nazroo, 1999) and enhance the accessibility of services (Benzeval & Donald, 1999).

The intersection of family poverty and unemployment on children's wellbeing has also been recognized in this policy era.

> "The vicious cycle of poverty, social exclusion, educational failure and ill health is mutually reinforcing. It needs to be broken. It can be broken. We know that good education is a route out of social exclusion and into prosperity. The time has come to recognize that health just like education is a route to economic fulfilment and personal fulfilment (Hutton, 2000, p. 8).

The most recent action plan (Britain, DoH, 2003 , July) proposes to introduce extracurricular sports and arts programmes in schools in disadvantaged neighbourhoods.

Introducing these as <u>health</u> initiatives shows the government is concerned to address the social conditions that contribute to health inequalities and in doing so has taken up issues of concern identified in this study. Such initiatives would create opportunities for youth to develop new forms of capital

This most recent plan, developed in part through consultation with community groups, (Britain, DoH, 2002, June) explicitly recognizes that ethnic minority groups are most likely to face material and social disadvantage in Britain and proposes strategies for addressing this. These include working in partnership with ethnocultural communities and voluntary organizations to develop appropriate programmes and resources and ensure their accessibility and to foster the development of strong integrated networks of support (Britain, DoH, 2003, July).

The current documents clearly recognize the social roots of health inequalities and have taken these up as health issues. In Britain then, a number of initiatives that seek to address the roots of health inequalities are in evidence in the broader policy and policy implementation plans. The central concepts evident in this policy discourse include; characteristics of the social, particularly neighbourhood, environment as a resource for health, the recognition of education as a resource for health and the recognition of community involvement through representation and partnerships as contributing to health. A goal evident in this policy is the interest in fostering social cohesion as a feature of the community that can contribute to health.

Furthermore, these health initiatives are further reinforced by concurrent initiatives within the SEU. This unit has an overarching mandate and a review of the extent of initiatives under their purview draws attention to efforts to recognize that inequalities are the

result of a range of conditions and that some sectors of the population are particularly vulnerable.

> "Ethnic minority people are more likely than the rest of the population to live in poor areas, be unemployed, have low incomes, live in poor housing, have poor health and be the victims of crime"(Britain, SEU, 1998, Cm 4045,p. 8).

These British policy initiatives represent a new era in social and health policy and announce the intention to recognize the links between social circumstances and health inequalities. As suggested by policies that have preceded them there is a need to ensure that the implementation plan receives the support it needs and that sufficient time is given to put the necessary changes in place before evaluations are undertaken.

So, a review of the policy details suggests that the British policy discourse has moved towards a vision of inclusion and has in the process proposed a number of initiatives to address the structural issues identified within this study as having important influences on the experience of marginalization.

Intersectoral Influences on Health Inequalities:

The Canadian Policy Discourse on Culture and Health

In Canada, the approaches to inequalities in health have been introduced through different routes. For example, in the last two decades, initiatives in health for immigrant populations have been influenced by legislative and policy initiatives in three major arenas. These include the Canada Health Act (Canada, 1984) and associated national health policy initiatives including 'Achieving Health for All' (Canada, 1986) the Canadian Multiculturalism Act of 1988 and associated policies and the Canadian Constitution Act of 1982. These legislative and policy initiatives have shaped the ways in which the discourse on culture and health has been framed and have, in turn, influenced how identified issues are responded to in policy and programme development. Two of these policies override all government initiatives whereas health policies are developed within the guidelines of the Canada Health Act (1984).

Changing patterns of migration to Canada have drawn attention to different perspectives on health held by professionals and cultural communities and raised awareness of the ways in which immigration influences individuals' capacities to access health care resources and mobilize personal resources to manage health and illness. In Canada therefore, particularly in provinces with high rates of immigration such as BC, introducing the Multiculturalism policy (BC, 1996) provides evidence that it has been argued, with some

degree of success, that attention must be paid to the examination of the ways migration and culture can be addressed in all government departments including health.

Additionally, many initiatives to address health needs of immigrant groups and cultural communities have for several decades been framed in relation to the Canadian Charter of Rights and Freedoms (Canada, 1982) which states under Section 15 (Equality Rights)

> "Every individual is equal before and under the law and has the right to equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability" (Canada, 2001/March).

As such, since its inception the Charter has been drawn upon by those arguing for changes in all sectors of society including the ways health services are organized and care is delivered in order to ensure equity.

In the past two decades Canadian health policy shows evidence of having broadened the view of health - beyond the traditional biomedical view - and accorded explicit recognition of the social determinants of health; including, gender, age, migration status and income. The theoretical and empirical work drawn upon to inform these national policy initiatives is described by Evans and colleagues (Evans et al, 1994). A review of the empirical work lends credence to the role of broader communities in fostering health. The current policy developed from the Epp Report completed in 1986 recognized the links between income and poor health that required attention.

> "Within the low-income bracket, certain groups have a higher chance of experiencing poor health than others. Older people, the unemployed, welfare recipients, single women supporting children and minorities such as natives and immigrants all fall into this category...So far, we have not done enough to deal with these disparities. As we search for health policies which can take this country confidently into the future, it is obvious that the reduction of health inequalities between high- and low income groups is one of our leading challenges" (Canada, 1986, p. 4).

During the 1980s much of the Canadian literature related to culture and health, or the health of immigrants, was prompted by the portrayal of Canada as a multicultural society with an attendant focus on understanding and celebrating diversity. A parallel literature focused attention on difficulties practitioners faced in attempting to deliver care to persons who did not speak English or who were unfamiliar with the system of health care delivery and hence faced barriers to access.

It was with the publication of the report of the Canadian Task Force on Mental Health Issues of Immigrants and Refugees in 1988 that widespread attention was drawn to the impact of migration on health. This Report contributed to a reconceptualization of the root causes of many of the problems health professionals identified as mental health issues, including the lack of community, social isolation and discrimination faced by immigrants and refugees. Thus, new perspectives were introduced into the discourse on culture and health and attention was drawn to the ways social context can potentially foster or impede health. In addition to making visible the extent of change faced by new immigrants, this report identified sub-groups within the immigrant populations whose needs for support and care had been greatly overlooked. The sub-groups identified include youth, women and the elderly (Canada, 1988a). The issues raised in this report resonate with experiences of marginalization described by participants in this research. They also point to mental health consequences of marginalization.

The health policy of this era focussed on *community building* initiatives and accorded recognition to the need for health care services to be *inclusive* and to recognize ways social conditions influence health. This perspective influenced how health policy was implemented and programmes were developed. At the federal level it led to the identification of priorities in programmes and resulted in a number of projects being funded that fostered community building and enhanced the awareness of health professionals regarding these issues.

The national mental health policy that was subsequently developed identified *partnership* and *mutual aid* as key concepts. This policy led to a number of initiatives to address isolation and the marginalization of persons within communities. The policy framework moved beyond biomedical views of health, illness and treatment and articulated a role for the informal sector as a resource for health. In keeping with the tenet of universality, the policy provides overarching concepts to guide programme development.

It is here that the equity principle has shown its value. For, at the implementation stage, there can be a requirement to demonstrate that resources have been allocated equitably, according to need and similarly to demonstrate the impact upon the population, or benefit in terms of desired health outcomes. As such, a number of initiatives, in health, in education, in social service programme development and in industry, explicitly recognized multiculturalism, and the diversity associated with it, as a feature of society.

Discourses on Culture and Health

The issues of culture, diversity and exclusion have received considerable attention in scholarship in Britain and to a lesser extent in Canada. It has however been observed that

despite considerable work in the British social policy arena, it is relatively recent in Britain that the exploration of the relationships between culture and health have been taken up in research.

My review of this literature identified scholars who have taken a range of positions and engaged in debate of the merits and consequences of conceptualizing culture as static or dynamic, processes of fostering identity or creating binaries through processes of othering. What this study draws attention to is the ways women's experiences of marginalization were socially organized and the ways popularized, accepted (unchallenged) images of immigrants influenced how they viewed themselves and their capacity to participate in society. While these conditions have implications for health and to a certain extent can be taken up in the health agenda, to address them requires initiatives in the broader societal domain.

Ahmad (1993a), in writing about studies of 'race' and health in the UK, argues that "the role of ideological considerations has been largely ignored in health and health service research on black populations" (p. 1). As argued in Chapter Two, the culturalist stance is problematized because it can be misused when everyone within a 'group' is considered to have the same experience. I addition by focusing attention on health profiles as associated with a cultural or ethnic group's beliefs and values it can eclipse the importance of other factors such as the impact of racialization or social location on health. Such a view, Ahmad argues, masks other processes operating.

> Similarly, Williams (1989) observes that:
>
> "although the step forward taken by ethnicity researchers was to examine culture from the immigrant's point of view and in a positive light...and to establish the reality of a multi-racial society, nevertheless, looking at 'minority - majority' relationships in a cultural framework excludes vital elements in the relation of 'race' to class and power, and institutionalized racism. This means, however sympathetic the cultural appreciation, it can still skew the analysis and 'blame the victim'" (p. 92).

Williams' observations resonate with the accounts of the participants in this study and draw attention to the need to recognize how other circumstances like gender, or material circumstances may intersect to create multiple forms of disadvantage.

While participants in this research had difficulties, they were not grounded in, or as a consequence of, their cultural beliefs or values. Rather, their difficulties were related to the ways their status as immigrants or refugees positioned them in their communities. It was this status, perpetuated in part by unchallenged assumptions held by others about immigrants and refugees, even once they became citizens, that positioned these women, their daughters

and families on the margins of the workforce, housing market or classroom. Furthermore, when material resources were not available and programmes were not universal, they had difficulty gaining access to contexts that could enable them to acquire broader social capital and gain entry to fields outside of their cultural or geographic communities.

In his appraisal of the health care system's response to persons of ethnic minorities in Britain Alexander (1999) problematises the concept of community. He challenges the assumption that people who are members of ethnic minorities constitute geographic and/or social communities. He therefore argues that programmes must take into account the ways communities are organized and notes that this may not coincide with the ways services are currently organized. Similar comments were made by a number of participants in this study.

Alexander's observations reverberate with Fenton and Charsley's (2000) "critical interrogation of the concept of ethnic groups as populations" (p. 406). While Alexander is pointing to structural constraints on the ways in which practice initiatives are undertaken, Fenton and Charsley argue that to assume because people have been categorized in a particular way they share common experiences or are part of a discrete population group, ignores the complexities of experience and disregards the ways in which other aspects of one's life intersect to shape it.

Ahmad also proposes that inclusive relationships are goals to strive for in addressing health inequalities.

> "These struggles for equitable health and health care are essentially located in the wider struggles for equity and dignity which have been a part of black people's history" (Ahmad, 1993a, p. 7).

Ahmad's writing points to a number of dilemmas. One is that the greatest influences on health lie outside of the traditional purview of the health care system. He observes the illhealth profiles being documented have social roots. However, this does not mean issues of exclusion or inequity do not also manifest themselves within the health care system. Both sets of issues must therefore be addressed.

Culley (1996) undertook a critical review of the literature to examine the theoretical premises of research in culture and health, particularly related to nursing in Britain. She took up an argument similar to that of Ahmad and issued a plea to move the discourse on culture and health forward.

> "(T)he experience of living in a society which is structured by gender, socio-economic and racial inequalities and the inter-relation between the living and working conditions of minority groups and their health status have been given less prominence than issues of 'cultural' difference and problems of

> communication. Not only are very important issues largely excluded from the debate, the dominant way of conceptualizing issues of 'race' and health has many serious flaws which may serve to obstruct the attainment of equitable health and health care" (Culley, 1996, p. 564).

Culley argues that the discourse in the British health care context is framed within a multicultural[9] perspective that centres on education and changing attitudes. She cites Stubbs (1993) in noting "within this discourse, the solutions to problems facing minority groups are 'essentially technical and professional rather than political'"(Culley, 1996, p. 565). Culley's analysis supports the view that a culturalist stance, while relevant to understanding individual's perspectives, is problematic when it shifts attention away from addressing structural conditions that show evidence of having important and persistent negative effects upon health.

Baxter, writing in 1997, makes the case for the education of health professionals about issues of equality in "multiracial Britain" of the 1990s. As well as outlining the poorer health profiles of people of colour she argues that their social location has roots in these population groups' migration history. A substantial number of those who immigrated from the Caribbean or Africa settled in neighbourhoods surrounding London, "where there was a demand for labour" (Baxter, 1997, p. 16). She observes:

> "A much higher proportion of black and ethnic minority people than white people are concentrated in areas with a high level of material and social deprivation, such as poor housing conditions and underemployment, and therefore they suffer from poor social and environmental and economic conditions. The pattern of social and economic inequalities is closely related to social class" (Baxter, 1997, p. 20).

She reminds the reader that people of colour are not all immigrants as many individuals and families arrived in Britain in the post war years. It is therefore not their status as newcomers that accounts for their social standing but rather the racializing practices of the broader society. While she sets out to enable professionals to understand the situations faced by racialized groups, in this book Baxter (1997) doesn't identify the structural or policy changes needed to begin to change the situations faced by racialized groups. In an earlier project undertaken with colleagues Baxter draws upon examples to enable professionals to develop skills in recognizing the nature of both social and structural barriers. These authors then

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[9] The term multicultural, like other terms holds different meanings. Culley's use of the term I interpret to be what Ahmad refers to as the culturalist approach. That is, a view of culture that focuses on beliefs, values shared by a 'cultural' group and one that does not direct attention towards the analysis of the social and institutional processes that influence action.

illustrate how such barriers can, through advocacy and policy change, be dismantled (Mares, Henley & Baxter, 1985). Baxter's comments align with Williams and Williams-Morris' observations in the US that racializing practices have changed slowly because assumptions are not challenged.

In the British context discussions on culture and health have conceptualized the experiences of racialized groups as embedded in broader social processes. This perspective takes the stance that the health of such populations is shaped by social location. Authors taking this position argue that the roots of health inequalities are inherently social and institutionalized in intergroup relations. The most recent policy initiatives in Britain have recognized and taken these up in their current policy initiatives.

Summary

It can be argued that health care systems have their own traditions that both define the nature of the health care enterprise and the roles people (professionals and patients) will play within them. Following from this then, in order to transform taken for granted power relations one must first have insight into the forces constraining change but also an understanding of the dynamics that sustain both traditions and relationships with others within a particular social context.

While formal policies may seek to redirect emphases in goals of care it is important to examine how formal policies are enacted in practice and to draw upon experiences at the 'local' level to assess the nature of change that has taken place. As discussed, the discourses of culture and health have developed in somewhat different ways in Britain and Canada. These discourses provide insight into the ways in which patient-professional, or community - health care system relationships and their associated practice traditions have developed. It is therefore against these histories that transformation must be considered.

One of the effects of marginalization is that people have fewer opportunities to influence the ways in which structures or policies are developed or to have a say in how policies are implemented (which in this case may include identifying for a given population group what strategies may be used most effectively). Further, while individuals can seek to act to change their own situations, to mitigate exclusion, such initiatives must be accompanied by institutional change. Smith argues that societies' institutions and associated policies and programmes replicate the relations of ruling.

Research on health inequalities, the social determinants of health, and the links between social support, community connections and health extensively cited here, and the

experience of the women who participated in this research, provide considerable evidence that health is influenced by conditions not well accounted for by biomedicine.

Research on health inequalities in Britain and on the social determinants of health in Canada, has clearly shown that persons who are disadvantaged are more likely to experience ill health. An examination of the ideological premises underpinning British and Canadian policies at different points in time suggest they have moved towards a commitment, albeit framed in different ways, to addressing the social conditions that contribute to inequalities in health.

Chapter 8

Summary, Conclusions & Recommendations

This chapter provides an overview of the problem of interest in this research and the approach used to examine it. Following this overview the main contributions of this research, the conclusions reached and the strengths and limitations of the study are described. The chapter concludes by identifying areas for further study.

An Overview of the Study and Thesis

This study builds from a programme of research that has shown the importance of the informal sector as a resource, a source of support, for individuals and a resource drawn upon by the health care system. Using the case of first generation immigrant women and their teenaged daughters the goal of this study was to explore the nature of their relationships with others in their communities as a way of understanding whether these women see the informal sector, specifically their relationships with others in it, as a resource. It was proposed that answering this question could provide a way of gaining insight into questions related to the role of the informal sector as a resource for health and could offer insights to the informal sector as a site for health care intervention.

While a number of theorists were drawn upon in conceptualizing this study, key theorists included Bourdieu (1990) and Smith (1986). The theoretical perspective that informed the study design and analysis was chosen because it builds from the premise that experiences are socially organized and provides direction for analysing individuals' experiences in relation to institutional structures and processes. Using this perspective then, the possibility of examining the ideological premises underpinning policy is created as is the possibility of writing women's voices into the policy process.

In this study a feminist stance was taken for feminist scholars, of which Smith is one, recognize that lives are gendered and socially organized. Many feminist scholars however, have not considered the additional influences on the lives of women of colour as central to their analyses, and many do not acknowledge the ways in which intercultural relations are historically grounded and institutionalized. Smith's recognition of broader social structures however provides a means for such issues to be considered. While Bourdieu is not acknowledged as a feminist, I viewed his work to be compatible with the goals of feminist inquiry because his perspective focuses attention on power and manifestations of power in

intergroup relations, and because his concepts draw attention to the ways in which historically constituted conventions are manifest in traditions and the social organization of societies. Also however, his perspective was seen to complement that of Smith in that it holds open the possibility of considering the ways in which 'race' intersects with gender and of exploring how these influence relationships.

The implications for health that stem from the analysis of the study participants' perspectives were then explored and discussed.

The study was undertaken in two countries because although Britain and Canada have similar systems of government, have made similar commitments to universal health care, and have accepted considerable numbers of immigrants there are differences in their policy stance. These points of similarity and difference offered the possibility of identifying the ways differences in policy or institutional practices could contribute to variations in these women's experiences.

The study participants were first generation immigrants or refugees and volunteers who were recruited through community based voluntary organizations in Britain and Canada. They lived in neighbourhoods described from census data as socially disadvantaged.

In keeping with the tenets of the theoretical perspective chosen a number of different forms of data were gathered. These included small group interviews with groups of women and individual interviews with women and their teen aged daughters. Data were also gathered from key informants working in different roles within the formal health sector. Following from the methods outlined by Smith (1987) policy documents and supporting research were also included as data for analysis.

The analytic perspective taken in this research offers the possibility of examining the ways in which multiple issues intersect to shape and define peoples' experiences. The methodological premises of this perspective require the researcher to engage with participants while also offering them a mechanism through the interviews to share their viewpoint and experiences. This first stage of data gathering and analysis is then followed by an examination of the ways in which these experiences were shaped by social and organizational processes.

Frequently people, like those included in this study, do not meet inclusion criteria of many research studies because of their written or spoken English language skills. This represents a systematic form of exclusion from the processes of knowledge generation. Although I did use translators in some interviews I did not have access to translators for all of the data gathering sessions so I too excluded women who did not speak English. As a

researcher who did not speak the first languages of the women being recruited I did face a number of obstacles in gathering data. For example, many of the women who participated in the study had limited written English skills. In these cases consent forms were read aloud and translated to ensure women who did participate were informed. Despite these obstacles, with the exception of one woman, all women participated in follow up individual interviews. Group and individual interviews were audiotaped and transcribed. The transcripts and related field notes comprised one data set analysed. These analyses were drawn upon to inform an examination of policy discourse and its ideological underpinnings.

Marginalization and Marginalizing Practices as Health Issues

The study provides insight into life after migration and the nature of the challenges women and their daughters face as they seek to become a part of their new communities. It also however, illustrates the ways this new terrain is navigated. As participants' accounts were analysed taking direction from Bourdieu's concepts it became evident that the process of establishing social relationships is a social exchange to which each participant brings resources or capital. Unfortunately, many of the participants were appraised by others as having little capital of value and were assigned 'to the margins'. Marginalization was evident in a range of contexts including experiences of downward mobility in the workplace, accounts of being socially excluded on the basis of stereotypical images and in incidents of violence or bullying experienced in the school or community. Their stories draw attention to the ways marginalization limits opportunities and could contribute to an erosion of the value of the participants' social history and sense of self. The accounts however, also draw attention to the conditions that did foster the converse and that created opportunities for capacity building.

Marginalization, as experienced by these participants, was associated with a lack of recognition of capital and an associated inability to access fields to employ or generate new capital. It therefore, in the most extreme forms, interfered with participants' abilities to engage in relationships and could contribute to a discounting of the individual by negating or minimizing a concern or issue.

The involvement of both mothers and teens as study participants drew attention to the uniqueness of the adolescent experience and the challenges they faced as they sought to respond to messages from the broader community while also redefining a place for themselves within their families and their new communities. Although all were living in families of limited means it was evident that those with fewer opportunities for capacity building faced greater challenges. This draws attention to the importance of supportive school environments but also community based activities in such areas as athletics or the arts.

The study also explored participants' views of health and access to health services. All viewed illness care as accessible via their GPs and despite the fact that several families had members with acute or chronic health conditions they viewed themselves as healthy. Their overriding concerns had to do with managing with limited material resources and their social location within, and treatment by, the broader community.

This study also shows the ways in which such experiences are socially organized. That is, in examining the migration stories it was evident from the accounts, downward mobility limited choice regarding neighbourhoods because of affordability and limitations associated with the types of work that was accessible to parents, created conditions that influenced the resources available to these families. They also structured the parents' availability for fulfilling other responsibilities. Additionally, accounts illustrated the ways people in authority within organizations could, by their action or inaction, convey messages that supported marginalizing practices.

This study adds to our understanding of the ways in which social conditions, in this case marginalization and marginalizing practices can create a context for health inequalities. The theoretical and empirical work in health inequalities draws upon a number of perspectives. A review of the major perspectives suggests that this research offers insights into the research that has shown social cohesion and integrated networks of support are associated with better health status over the life course. It was argued that policies of inclusion, particularly initiatives that recognize inequities in resources and that foster capacity building within communities, have the potential to redress the marginalization experienced and thereby contribute to an improvement in health inequalities profiles of ethnic minority communities.

An examination of the health policy discourse reveals that the most recent policy initiatives in Britain have shifted to recognize social conditions in the health agenda and have explicitly recognized the rights of all individuals. These two commitments along with initiatives under the auspices of the SEU make important contributions to an agenda of inclusion and will hopefully contribute to a shift away from marginalization towards inclusion.

These new policy initiatives represent important ideological shifts in that they consider interventions within the social domain as health initiatives. For example, health initiatives include capacity building within the community, the provision of sports and recreation activities within schools and involvement of voluntary organizations as partners in health care. An ideological shift can also be identified with discourses of inclusion being

taken up in British health policy. The most recent policy document (Britain, DoH, 2003, July) seeks to ensure all initiatives are mainstreamed and seen as central to the NHS mandate.

The study data do suggest that as new policies aimed at reducing inequalities in health are introduced they must attend to the ways they are implemented and seek to ensure coherence within organizations from the point of policy articulation to the front line. It will be important to ensure that practitioners, professionals and others involved in the formal health care delivery enterprise have an understanding of the ways in which our actions, as persons in authority, can contribute to processes of marginalization.

In Canada as well, the recent federal inquiries into health care have reiterated previous commitments to universality while recognizing diversity and seeking to ensure equity. While health care reorganization accompanying reform that was prompted by reductions in funding over the past decade appeared to place some programmes in jeopardy, the recent decision to increase federal funding allocations without changing the primary premises of policy can be seen as a recommitment to these ideologies.

What then can be concluded from these findings? This study set out to answer three questions.

Conclusions

How do first generation immigrant women and daughters view their social location and characterize their relationships with others?

Relationships were important, and when they were in place they played key roles as resources for the study participants. However, the overriding message from the study participants was that relationships were characterized by marginalization. Marginalization was characterized as a sense of inbetweenness as well as a sense of being overlooked, categorized or misrepresented. Marginalization as experienced by these participants was enacted in many contexts and for some, led to exclusion.

The process of marginalization had an impact on a several levels.

The first is the way marginalizing practices such as making one's concerns or viewpoint invisible, or not recognizing a potential contribution or capital, prompts individuals to question the legitimacy of their feelings or the value of their abilities.

The second is when mothers and teens discover the 'rules' of eligibility - of friendship, of employment, of establishing relationships with others in schools or neighbourhoods - may exclude them or limit their choices. What the participants viewed to be particularly problematic was that the 'rules' were often based upon illfounded

assumptions about them, or were related to unchallenged generalizations about immigrants, refugees, or women.

The third is observed when resources or programmes of core societal organizations are premised upon assumptions about individuals' abilities to access or participate, that do not hold across all sectors of the community. This creates barriers to access.

The mothers and daughters involved in this research were engaged in a complex process of change and development. It was important for them to have a say in what place, or social location, they would take up or assume. Some participants engaged in challenging, more or less successfully, perceived misrepresentations or injustices.

What resources (forms of capital) do first generation immigrant women and daughters draw upon, and contribute to different fields of encounter?

The answer to this research question builds from the first question. That is, as the participants spoke of their relationships with others and the ways they were influenced by marginalizing practices, it became evident that an important feature of relationships was their reciprocal nature. That is, while participants might describe benefits (information, support, assistance, understanding) derived from friendships it was also important to have opportunities to contribute within relationships. That is, opportunities to share their own expertise, understandings, their capital. For both mothers and daughters the recognition of their ability to contribute as well as the recognition of particular contributions was spoken of as forms of affirmation.

Marginalization influenced the ways relationships with others, in both neighbourhoods and the broader community were constituted. It could also interfere with constituting relationships with resources, persons or organizations that were part of the formal health care sector.

Mothers were more able than their daughters to draw upon personal experiences to challenge the, often negative, preconceived notions about immigrants, or refugees, that they were presented with. Mothers also seemed more prepared to accept their social location as a consequence of migrating, and one that they were prepared to go along with, in part because they thought they were providing a better future for their children.

Many of the mothers drew upon previous education, work and professional experiences in their home countries as well as their experiences post migration to contribute to the work of community based voluntary organizations. They also drew upon their own knowledge and experience to advocate for their children and in some instances to advocate for others deemed more vulnerable within the community. Participating in these voluntary

roles frequently offered the only forums for these women to make a contribution and to receive recognition or affirmation from others about their abilities. Such participation also created some opportunities for participants to access new forums. As such, mothers frequently sought out opportunities for their daughters to participate and to receive recognition.

Despite their efforts many participants felt their access to new fields was constrained because of assumptions about immigrants or refugees. While teens also spoke of marginalizing practices a number of them were actively engaged in negotiating their social status, particularly in the school context. That is, a number of teens engaged with others to renegotiate the ways they saw themselves as being viewed. In doing so they drew upon competencies, or social capital, that held value in different contexts. Some were fortunate to be good athletes, good students, good musicians, good contributors to the family or good friends.

Other teens, did not have the capital to draw upon and in some of these cases became targets of violence or bullying. They were vulnerable as a consequence of difficulties they were facing and had few personal, family or network resources to draw upon.

All teens engaged in reflecting upon the representations of them put forward by others. As teens shared these processes of reflection it became evident marginalization did prompt teens to consider themselves as less valued, less competent and in some instances less hopeful about the future. They felt sentenced to a future on the margins.

While many of the mothers were actively engaged in developing networks with others who could advocate or link them with other types of resources, teens too worked to develop networks. As noted above in many cases teens felt they needed to distance themselves from their families (sources of negative capital) in order to gain some credibility with groups, often of peers. Unfortunately for some of them the peers also had limited resources to draw upon and so while they could provide some forms of support, they were not in a position to offer guidance, or enable a teen to make links (to new fields) outside of the generally limited network.

What is the nature of first generation immigrant mothers and their daughters' relationships with informal and formal health care systems?

The study participants generally viewed the formal system as a resource for illness care and in some instances had, or were currently drawing upon it for support in managing early childhood or maternal child health issues. There were some examples of participants commenting upon barriers they observed to illness screening programmes or education

programmes related to the signs, symptoms and risks factors for particular, often unfamiliar, forms of illness. Of note is that none of the teens were familiar with nursing roles or resources within their schools.

Persons in different roles within the formal system were interviewed as key informants. They spoke about their roles as client advocates, described the resources available to immigrant groups (such as interpreter services) or the challenges they faced in implementing policy with immigrant groups. Such challenges included implementing new priorities while maintaining service levels with similar resources, or seeing the consequences of poverty but not having resources to address them.

All participants spoke of the important role played by different voluntary organizations in providing information, facilitating access to resources of the formal system, and in some instances resources of the informal sector, through the provision of information or by enacting an advocacy role. Participants also spoke of the opportunities voluntary organizations provided for capacity building and described the sense of affirmation they received by having their concerns and their contributions valued by the organizations and people within them. Voluntary organizations fulfilled a variety of functions for the study participants including enabling them to gain access to new or different fields while also facilitating the establishment of relationships with others.

Reflections on the Relevance of Bourdieu and Smith to Health Research

This research has shown that processes that have been identified in research on social systems are also in operation in health systems. Bourdieu's conceptualization offers an alternative to a view of culture as a static set of beliefs or values shared among a defined group, provides direction for understanding the ways social relationships are constituted and sheds light on the processes of assigning social value.

I found Bourdieu's concepts useful in that I was able to consider the different forms and manifestations of *habitus* and capital while also examining how these were drawn upon as resources and, in some instances, transformed to take into account the new social circumstances the families were seeking to locate themselves in. Within this perspective there is both a mechanism for exploring cultural systems and practices of importance to individuals while also recognizing the ways in which such practices change with changing circumstances.

Bourdieu's perspective offers the possibility of analysing peoples' experiences not as solely individual experiences, but also as experiences that accrue from the ways in which society is organized. The significance of this for research in culture and health is that we gain insights into ways of understanding and working with individuals. Such insights could allow us to consider change at the organizational, or policy, level that may rectify existing

inequalities or take these into account as programmes are being developed or care is being provided.

Throughout the study Bourdieu's concepts enabled me to focus attention on the different forms of capital held and drawn upon by women in managing their day to day circumstances. The study participants' accounts and their representations of women's capital, in the form of resourcefulness, creativity and inventiveness in their approaches to managing with limited material capital stand in contrast to the many images offered in the popular press and media of immigrants and refugees as burdens on society who, if not checked, will sap the resources of society. They also however point to the, often negative and cumulative, effects of lack of material capital and social capital on people's capacity to pursue a health agenda.

Bourdieu's conceptualization of the value of capital as a social construct is also particularly useful for understanding these participants' experiences. As noted, many of the women and their husbands had work and educational backgrounds that they were unable to capitalize upon in their new communities. In this study the direction provided by the concepts focused attention on the forms of capital drawn upon and contributed to different family and community initiatives. If I had not employed Bourdieu's concepts as a lens it is likely such resources would go largely unacknowledged, as they often do in a general health or community assessments, because they are eclipsed by other social markers. Of equal importance however, is the recognition that capital accrues value in a socially determined context. While this has been illustrated by Bourdieu's analyses of different presentations of cultural capital, this notion has not been considered for processes that relate to health. These observations underscore the need to consider multiple perspectives in assessment and planning. They also however point to the need for a critical appraisal of the health structures and processes, including assessment, that structure practice.

The conceptualization of capital is particularly useful in considering the teens' experiences for it draws attention to the forms of capital held by youth and the gaps between these forms of capital and capital recognized as holding value by broader society. Bourdieu's concepts of capital and field also provided direction for the analysis of the ways in which exclusion is constructed. These concepts allowed me to interpret the data to illustrate how the social barriers faced by many of these teens are erected and maintained. But also how, in some circumstances, they were challenged.

Methodological Critique & Areas of Further Study

The analytic perspective, as applied in this study, draws attention to the need for health care professionals to examine assumptions about minority populations and consider resources of, and resourcefulness within, cultural communities that can be drawn upon in the design and delivery of health programmes.

Feminist theorists have been relatively successful in drawing attention to the ways society has historically undervalued and overlooked the importance of the largely taken for granted world and work of women. Smith's perspective offered a means for exploring more fully the ways in which the formal health care system relies upon resources of the informal sector to support its work and the vulnerabilities that can accrue if such resources are not available.

This study was designed to capture first generation immigrant women's perspectives on their relationships with others as a step towards writing women's voices into policy. As was evident in the review of policy documents this is not the standard approach to policy development. It is likely that some will view the qualitative approach to be limited in its ability to inform the policy process. This is in part why the women's accounts are considered in relation to broader premises of policy. This form of inquiry provides a viewpoint from which new questions about the adequacy of policy can be posed. In this regard I think the study was successful. This perspective is also consistent with the premises of healthy public policy and of participatory inquiry which are increasingly being advocated in the policy planning process.

As the study was designed to include only immigrant women it may be that women, who are not immigrants, who are of limited material means may also share some of these experiences. It has been argued by some theorists that there is a hierarchy shaped by gender and 'race'. It may be that men who are also first generation immigrants also face similar challenges. Future research should seek to include both immigrant and visible minority women and men as well as women more representative of the 'mainstream' as a way refining our understanding of the influences of gender and 'race' on marginalizing practices.

Similarly, while I was only able to include women who were able to speak English in part because of a limit on resources but also in part because many researchers and practitioners assume that difficulties faced by new immigrants are primarily related to language and can therefore all be resolved by encouraging language development or providing interpreter support. This study challenges this assumption by showing that despite language skills women faced a number of challenges in establishing relationships with persons in new fields. We may assume that women without language skills would feel

even more marginalized, but it would be useful to have an understanding of the similarities and differences in the experiences of women without language skills to those of women in this study.

This study began by gaining an understanding of women's experiences and proceeded to analyse the ways these are socially organized. In doing so the emphasis shifted to focus on the structural conditions that shaped experience. Upon reflection more attention could be paid, through re-examination of the data to the women's responses. That is, to analyse their perspectives on 'agency'. There are glimpses of this in the analysis but more could be learned by systematically examining the ways women responded. This will be an area of further study.

While policy documents were examined, and research that informs such policy initiatives was reviewed, data related to the policy development and implementation process can only be inferred from such documents. A study using a participatory framework to include the perspectives of those in the policy development roles together with women like those who participated in this study would provide a more indepth understanding of the challenges of incorporating women's voices into the policy development process.

Similarly, the analysis undertaken here lends support to the policies of inclusion in health. The Canadian data also suggest that change of the sort desired here comes slowly and must be taken up at all levels. It would be valuable to undertake follow up studies with comparable populations in this new policy era to document successes while also identifying areas of ongoing challenge.

I did interview key informants but many of these were not in front line roles, they were in intermediary roles working towards translating policy into practice. Given the insights the participants offered about relationships, it would be informative to undertake research with practitioners and clients at the frontline as they negotiate access to service or deliver services. For this would be a context for appraising the extent to which the inclusive policy initiatives currently being undertaken have taken hold.

I have taken the position that this study adds to the work of theorists who view relationships as having a protective influence on health and that inclusive societies may facilitate the development of such relationships. While this study provides evidence of the importance of such relationships to women and teens, exploring these questions and the relationships between these conditions using both qualitative and population based studies will enable us to understand the significance of these findings at the population level.

While this study is broadly concerned with relationships as resources identified as having a protective health function over the life course. These study data identify

marginalization as a threat to the development of such relationships for first generation immigrant women. Without further research correlating measures of health status with indicators of marginalization we cannot conclude such initiatives will ultimately change population profiles of health inequalities.

The insights into teens' experiences add context and depth to emerging surveys of youth health that raise concern about teens' mental health. While teens in general are viewed to be healthy, these teens' accounts offer insight into processes that can lead to acquiring a sense of being capable and valuable or the converse. They merit exploration in further study.

The nature of the participants' relationships with voluntary organizations draws attention to the possibilities for, and consequences of, capacity building and community building as aspects of the health policy agenda. They also underscore the need to attend to the adequacy of community based resources for teens and others whose perspectives are overlooked in policy and planning.

This study suggests that fostering capacity building and fostering social cohesion hold promise as health interventions. This study offers insight into the role resources of the informal sector play in supporting individuals to navigate the day to day challenges of health promotion and illness management. Further exploration of capacity building and community building initiatives among youth in general and marginalized youth in particular would be of value.

Summary

The study data gathered from first generation immigrant women and their teenaged daughters, draw attention to the overlapping and cumulative nature of events that create a context for exclusion. This suggests that a commitment to redressing exclusion and its effects must be intersectoral and focus attention at all levels. Bourdieu and Smith's perspectives and the analysis undertaken here focused attention on the extralocal conditions that foster and perpetuate such practices. Drawing upon these theorists' perspectives in conceptualizing and undertaking this research has enabled the discovery of new explanatory perspectives on the ways in which social processes can impact health. One process of particular interest and one central to the experience of participants in this study is marginalization.

This study began by describing women's experiences and then, taking direction from Bourdieu and Smith, proceeded to consider the extralocal conditions that shaped them. It offers insights into the ways in which policies, the ideological premises that underpin them and the institutional practices associated with them contribute to the creation of social conditions. In this study the case is made that attending to ideological premises of policy and

how these are enacted in practice, when considered in relation to viewpoints of those outside the policy process, can offer guidance for change or serve as hallmarks of success.

References

Abel-Smith, B. (1994) *An Introduction to Health Policy, Planning and Financing*. Longman, London.

Adeyi, O., Lovelace, J.C. & Ringold, D. (1998) In defense and pursuit of equity and efficiency. *Social Science and Medicine*, 47(12): 1899-1900.

Ahmad, W.I.U. (1992) ed. *The politics of 'race' and health.* Bradford: Race Relations Unit, University of Bradford and Bradford and Ilkley Community College.

Ahmad, Waqar, I.U. (1993a) ed. *'Race' and health in Contemporary Britain.* Buckingham, Open University Press.

Ahmad, Waqar, I.U. (1993b) Making black people sick: 'race', ideology and health research. In W.I.U Ahmad, ed. *'Race' and health in Contemporary Britain.* Buckingham, Open University Press: 11-33.

Ahmad, W.I.U. (1996) The trouble with culture. In D. Kelleher & S. Hillier, eds. (1996) *Researching Cultural Differences in Health.* Routledge, London. pp. 190- 219.

Alexander, Ziggi (1999) *The Department of Health: Study of Black, Asian and Ethnic Minority Issues.* Study Commissioned by the British Department of Health, London. September.

Anderson, J.M. & Lynam, M.J. (1987) The meaning of work for immigrant women in the lower echelons of the Canadian labour force. *Canadian Ethnic Studies*, XIX(2): 67-90.

Anderson, J.M., Dyck, I. & Lynam, M.J. (1997) Health care professionals and women speaking: Women's lives and the management of chronic illness. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine.* 1(1): 57-80.

Anderson, J.M. (1990) Home care management in chronic illness and the self-care movement: An analysis of ideologies and economic processes influencing policy decisions. *Advances in Nursing Science*, 12(2): 71-83.

Anderson, J.M. (1996) Empowering patients: Issues and strategies. *Social Science and Medicine.* 43(5): 697-705.

Anderson, J.M. (2000) Gender, "race", poverty, health and discourses of health reform in the context of globalization: a postcolonial feminist perspective in policy research. *Nursing Inquiry*, 7: 220-29.

Anderson, J.M. & Elfert, Helen (1989) Managing chronic illness in the family: Women as caretakers. *Journal of Advanced Nursing*, 14:735-43.

Angus, J. (1994) Women's unpaid/paid work and health: Exploring the social context of everyday life. *The Canadian Journal of Nursing Research*, 26(4): 23-42.

Annandale, E. & Hunt, K. (2000) *Gender Inequalities in Health.* Open University Press, Buckingham.

Arber, Sara (1997) Comparing inequalities in women's and men's health: Britain in the 1990s. Social Science & Medicine, 44(6): 773-87.

Arber, Sara & Cooper, H.(2000) Gender and inequalities across the life course. In. Ellen Annandale & Kate Hunt, eds. *Gender and Inequalities in Health.* Open University Press, Buckingham, pp. 123- 149.

Arskey, Hilary (1998) Collecting data through joint interviews. *Social Research Update,* 30 January, (15): Department of Sociology, University of Surrey, Guildford, England.

Backett, K. (1990a) Image and reality: health enhancing behaviours in middle class families. *Health Education Journal*, 49(2): 61-3.

Backett, K. (1990b) Studying health in families: a qualitative approach. In S. Cunningham-Burley & N.P. McKeganey, eds. *Readings in Medical Sociology.* London: Routledge.

Badgeley, R.F. & Wolfe, S. (1967) *Doctors' Strike: Medical Care and Conflict in Saskatchewan.* Toronto, McMillan.

Bannerji, H. (1991) But who speaks for Us? Experience and agency in conventional feminist paradigms. In. H. Bannerji, L. Carty, K. Delhi, S. Heald, & K. McKenna, eds. *Unsettling Relations: The University as a Site of Feminist Struggles*. Women's Press, Toronto. pp. 67-107.

Bartley, M., Blane, D. & Smith G. D., Eds. (1998) *The Sociology of Health Inequalities*. Blackwell, London.

Bartley, M., Blane, D. & Smith G. D. (1998) Introduction: Beyond the Black Report. In Mel Bartley, David Blane & George Davey Smith, Eds. *The Sociology of Health Inequalities*. Blackwell, London.pp. 1-16.

Baxter, Carol (1997) *Race inequality in health care and education.* Balliere Tindall, London.

Benzeval, Michaela (1997) Health. In A. Walker & C. Walker, eds. *Britain Divided: The growth of social exclusion in the 1980's and 1990's.* CPAG, London. pp. 153-69.

Benzeval, Michaela (1999) Tackling inequalities in health: How can we learn what works? *Eurohealth*, 5(1): 29-33.

Benzeval, Michaela & Donald, A. (1999) The role of the NHS in tackling inequalities in health. In Gordon, David, Shaw, M., Dorling, D. & Davey Smith, G. eds. (1999) *Inequalities in Health: The evidence. The evidence presented to the Independent Inquiry into Inequalities in Health*, chaired by Sir Donald Acheson. The Policy Press, Bristol. pp. 87 – 99.

Berger, Peter & Luckmann, Thomas (1966) *The social construction of reality: A Treatise on the Sociology of Knowledge*. Doubleday and Co., New York.

Berkman, L.F. & Smye, L. (1979) Social networks, host resistance and mortality: A nine year follow up of Alameda County residents. *American Journal of Epidemiology*, 109(2): 186-204.

bhabha, homi (1994) *the location of culture.* Routledge, London.

Billings, J. & Cowley, Sarah (1995) Approaches to Community Needs Assessment: A Literature Review. *Journal of Advanced Nursing*, 22: 721-730.

Black, D., Morris, J.N., Smith, C., Townsend, P. (1992) Inequalities in Health (The Black Report). In P. Townsend & N. Davidson, eds. *Inequalities in Health and the Health Divide*. Penguin Books, London, pp. 31-213.

Blaxter, M. (1989) A comparison of measures of inequality in morbidity; in A.J. Fox ed. *Inequalties in Health within Europe*. Gower Press, Aldershot.

Blaxter, M. (1990) *Health and Lifestyles*. Tavistock/Routledge, London.

Blaxter, M. (1997) Whose fault is it? People's own conceptions of the reasons for health inequalities. *Social Science & Medicine*, 6: 747-756.

Blaxter, M. & Paterson, E. (1982) *Mothers and Daughters: A Three Generation Study of Health Attitudes and Behaviours*. Heinemann Educational Books, London.

Block, M.A. (1997) Comparative research and analysis methods for shared learning from health system reforms. *Health Policy*, 42: 187-209.

Bourdieu, Pierre (1986) 'The three forms of capital' in J.G. Richardson, ed. *Handbook of Theory and Research for the Sociology of Education*, Greenwood Press, New York.

Bourdieu, Pierre (1990a) *The logic of practice*. (translated by Richard Nice) Polity Press, Cambridge.

Bourdieu, P. (1990b) *In Other Words: Essays towards a Reflexive Sociology*. Cambridge, Polity Press.

Bourdieu, Pierre (1994) Structures, Habitus, Power: Basis for a theory of Symbolic Power. Chapter in Nicholas Dirks, G. Eley, & Sherry Ortner, Eds. *Culture/Power/History: A Reader in Contemporary Social Theory*. Princeton, Princeton University Press: 155-199.

Bourdieu, Pierre (1997) *Pascalian Meditations*. Stanford University Press, Stanford.

Bourdieu, Pierre (1998) *Practical Reason: On the Theory of Action*. Policy Press, Cambridge.

Bourdieu, Pierre & Wacquant, Loic (1992) *An Invitation to Reflexive Sociology*. Polity Press, Oxford.

Bourdieu, Pierre and Accardo, A., Balazs, G., Beaud, S., Bonvin, F., Bourdieu, E. Bourgois, P., Boccolichi, S., Champagne, P., Christin, R., Faguer, J., Garcia, S., Lenoir, R., Oeuvrard, F., Pialoux, M., Pinto, L, Podalydes, D., Sayad, A., Soulié, C. & Wacquant, L. (1999) *The Weight of the World: Social Suffering in Contemporary Society*. Policy Press, Cambridge.

Bourne, J. (1980) Cheerleaders and Ombudsmen: the Sociology of Race Relations in Britain. *Race and Class*, XXV, p.340- 355.

Bradby, H. (1995) Ethnicity: not a black and white issue. A research note. *Sociology of Health and Illness*, 17(3): 4005-417.

Bridges, Jacqueline, M. & Lynam, M. Judith (1993) Informal Carers: A Marxist analysis of social, political, and economic forces underpinning the role. *Advances in Nursing Science*, 15(3): 33-48.

Britain, Department of Health and Social Security (1980) *Inequalities in Health: Report of a Working Group Chaired by Sir Douglas Black*, DHSS. London.

Britain, DoH (1989) *Working for Patients:* White Paper, Cm. 555, HMSO, London.

Britain, DoH (1991) *The Health of the Nation: A consultative document for health in England.* Her Majesty's Stationery Office (HMSO), Cm. 1523, London.

Britain, DoH (1996) May. *Directory of Ethnic Minority Initiatives*. Publication of the Department of Health, London.

Britain, DoH (1998d) February. *Our Healthier Nation: A Contract for Health. A Consultation Paper.* HMSO Cm 3852, London.

Britain, DoH (1998a) November. *Independent Inquiry into Inequalities in Health*, Chaired by Sir Donald Acheson. http://www.official-documents.co.uk/document/doh/ih/.

Britain, DoH (1998b) *Independent Inquiry into Inequalities in Health*, Chaired by Sir Donald Acheson (also referred to as the Acheson Inquiry). HMSO, Norwich.

Britain DoH (1998c) *Underage pregnancies: Public Health Common Data Set.* London School of Hygiene and Tropical Medicine, London.

Britain, DoH (1999a) *Our Healthier Nation.* Department of Health Web site. Document updated, 6 July, 1999.

Britain, DoH (1999, 6 July). *The Health of the Nation - a Policy Assessed.* Two reports commissioned for the Department of Health from the Universities of Leeds and Glamorgan and the London School of Hygiene and Tropical Medicine. HMSO, London.

Britain, DoH (1999b) *Our Healthier Nation: Saving Lives*. Department of Health, July 1999, HMSO Cm 4386, London.

Britain, DoH (2000) Milburn, A. *The NHS Plan: A Plan for Investment: A Plan for Reform* @ www.nhs.uk/nhsplan.

Britain, DoH (2002) June *Tackling Inequalities: The results of the Consultation Exercise*. Crown Copyright. DoH Publication # 28246. London.

Britan, DoH (2003) July *Tackling Health Inequalities: A programme for Action.* London, DoH Publication # 32366. London. Also www.doh.gov.uk/healthinequalities/programmeforaction

Britain, Home Office (HO), Jackson, K. & Bennett, A. (1998, October 29) *Control of Immigration: Statistics United Kingdom, First Half 1998.* Issue 24/98. www.home office.gove.uk/rds/pdfs/hosb1401.pdf

Britain, HO, Watson, M. & McGregor, R. (1999, May 27) *Asylum Statistics United Kingdom 1998.* Issue 10/99. http.//www.home office.gove.uk/rds/pdfs/hosb.pdf

Britain, HO, (2000, March) *Race Equality in the Public Services*, Home Office, London.

Britain, HO (2001a) *Race Relations (Amendment) Act 2000.* Crown Copyright 2000, 2001 page amended 25 July 2001. http://www.homeoffice.gov.uk/raceact/textnote.htm

Britain, HO (2001b) *Race Relations (Amendment) Act 2000.* Chapter 34. http://www.legislation.hmso.gov.uk/acts/acts2000/00034--a.htm

Britain, HO (2001c) *Race Relations (Amendment) Act 2000. Text of 2000 Act and explanatory notes.* Page amended 25 July, 2001. http://homeoffice.gov.uk/raceact/textnote.htm

Britain, HO (2001d) *Guide to the Race Relations 1976 Act.* Page Amended 19 February, 2001. http://www.homeoffice.gov.uk/raceact/guide.htm

Britain, Social Exclusion Unit (SEU) (1998) *Bringing People Together: A National Strategy for Neighbourhood Renewal.* HMSO, Cm 4045, London.

Britain, SEU (2001) Preventing Social Exclusion: Report by the Social Exclusion Unit. Crown Copyright, London. March.

British Columbia (BC)(1992) *Closer to Home. Report of the British Columbia Royal Commission on Health Care and Costs*. B.C. Ministry of Health, Victoria.

B C (1995) *Policy Frameworks on Designated Populations*. New Directions Development Division, Ministry of Health and Ministry Responsible for Seniors, Victoria.

BC (1996) *A Report on the Health of British Columbians. Provincial Health Officer's Annual Report, 1995.* Feature Report, Women's Health. B.C. Ministry of Health and Ministry Responsible for Seniors, Victoria.

BC (1996) *Multiculturalism Act*. RSBC, Ch.321, Victoria. http://www.mcaws.gov.bc.ca/amip/prgs/policy.htm

BC (1998) *Unfulfilled expectations, Missed Opportunities: Poverty among Immigrants and Refugees in British Columbia*, Prepared for the Working Group on Poverty by Martin Spigelman Research Associates, October, 1998. Funded by BC Ministry Responsible for Multiculturalism and Immigration, Immigration Policy, Planning and Research Division.

Browne, A. (2001)The influence of liberal political ideology on nursing science. *Nursing Inquiry*, June 8(2): 118-30.

Brownell, M.D., Roos, N. & Burchill, C. (1999) Monitoring the impact of hospital downsizing on access to care and quality of care. *Medical Care*, 37(6): JS135-50.

Butterfield, Patricia (1991) Thinking upstream: Nurturing a Conceptual Understanding of the Social Context of Health Behaviour. In. Karen Saucier, ed. *Perspectives in Family and Community Health.* C.V. Mosby, Toronto. pp. 66-71.

Campbell, C. & McLean, C. (2002) Ethnic identities, social capital and health inequalities: factors shaping African-Caribean participation in local community networks in the U.K., *Social Science & Medicine*, 55: 643-57.

Canada (1964) *Royal Commission on Health Services Report.* Queen's Printer, Ottawa.

Canada (1974) *A New Perspective on the Health of Canadians.* (The Lalonde Report). Health & Welfare Canada, Queen's Printer, Ottawa.

Canada (1982) *Charter of Rights and Freedoms.* Queen's Printer, Ottawa.

Canada (1986) *Achieving health for all: A Framework for Health Promotion.* Ottawa: Department of Health and Welfare.

Canada (1987) *The Active Health Report - Perspectives on Canada's Health Promotion Survey, 1985.* Health and Welfare Canada, Ottawa.

Canada (1988a) *After the door has opened: Mental health issues affecting immigrants and refugees in Canada.* A report of the Task Force on Mental Health Issues Affecting Immigrants and Refugees. Ottawa: Minister of Supply and Services. Cat. No. Ci96-38/1988E.

Canada (1988b) *Mental Health of Canadians: Striking a Balance.* Ministry of National Health and Welfare. Ministry of Supplies and Services Canada. Cat. H39-128/1998E.

Canada (1994) *Strategies for Population Health: Investing in the Health of Canadians.* Discussion Paper prepared by Federal, Provincial and Territorial Advisory Committee on Population Health. Health Canada, Ottawa. Cat. H39-316/1994E.

Canada, (1997a) *Canada Health Action: Building on the Legacy.* Report of the National Forum on Health Volume 1. The Final Report. (http://wwwnfh.hc-sc.gc.ca/publicat/finvol1)

Canada (1997b) *Canada Health Action: Building on the Legacy.* Report of the National Forum on Health. Volume 2. Synthesis Reports and Issues Papers. (http://wwwnfh.hc-sc.gc.ca/publicat/finvol2).

Canada (1998a) Citizenship and Immigration Canada, Landed Immigrant Data System.

Canada (1998b) 1996 Census Tables. Statistics Canada, Housing, Family and Social Statistics Division. http://www.statcan.ca/

Canada (2001/March) *The Health of Canadians - The Federal Role.* Interim Report. Vol. 1 - The Story So Far. Ottawa: The Standing Senate Committee on Social Affairs, Science &

Technology@http://www.parl.gc.ca/3711/parlbbus/commbus/senate/con.e/soc1-E/vep-e/reprintmar01-e-htm.

Canada (2001) Statistics Canada, *Profile of Immigration*, by urban centre, province and source countries. . http://www.statcan.ca/

Canada (2002a) *Shape the Future of Health Care.* Interim Report of the Royal Commission on the Future of Health Care in Canada.. Roy Romanow, Commissioner. Queen's Printer, Ottawa. Cat. no. CP32-76/2002 E-IN

Canada (2002b) *Building on Values: The Future of Health Care in Canada.* Commission on the Future of Health Care in Canada. Final Report. Roy J. Romanow, Commissioner. National Library of Canada. Cat. # CP 32-85/2002E-IN

Carby, H. (1982) Schooling in Babylon and white women listen! Black feminism and the boundaries of sisterhood. In CCCS, *The Empire Strikes Back: Race and Racism in '70's Britain.* London: Hutchinson University Library.

Castonguay, Claude (1972) *Report of the Commission of Inquiry on Health and Social Welfare*, Editeur Officiel du Québec, Québec.

Chalmers, K. & Kristajanson, L. (1989) The theoretical basis for nursing at the community level: A comparison of three models. *Journal of Advanced Nursing*, 14: 569-74.

Chen, J., Ng, E. & Wilkins, R. (1996) The health of Canada's immigrants 1994-5. Statistics Canada, Cat. No. 82-003. *Health Reports*, 7(4): 33-45.

Chesler, P. (1972) *Women and madness.* New York, Doubleday.

Chrisman, N. (1977) The health seeking process: An approach to the natural history of illness. *Culture, Medicine & Psychiatry*, 1(4): 351-77.

Chrisman, N. & Kleinman, A. (1983) Popular health care, social networks and cultural meanings: the orientation of Medical Anthropology. In D. Mechanic, ed. *Handbook of Health, Health Care and the Health Professions.* The Free Press, New York. pp. 569-90.

Cicourel, A. V. (1974) *Cognitive Sociology, language and meaning in social interaction.* The Free Press, New York.

Cicourel, A.V. (1976) *The social organization of juvenile justice.* Heinemann, London.

Cohen, S. & Syme, S.L., eds. (1985) *Social Support and Health*, Academic Press, New York.

Cooper, Helen, Arber, S., Fee, L. & Ginn, J. (1999) *The Influence of Social Support and Social Capital on Health: A Review and Analysis of British Data.* Health Education Authority, London.

Corin, E. (1994) The Social and Cultural Matrix of Health and Disease. In R. Evans, M. Barer & T. Marmor, eds. *Why are some people healthy and others not? The Determinants of Health of Populations.* Aldine de Gruyter, New York. pp. 93-132.

Cotterill, Pamela (1992) Interviewing women: Issues of Friendship, vulnerability and power. *Women's Studies International Forum*, 15(5/6): 593-606.

Cowley, Sarah & Billings, J. (1999a) Resources revisited: Salutogenesis from a lay perspective. *Journal of Advanced Nursing*, 29(4): 994-1004.

Cowley, Sarah & Billings, J. (1999b) Implementing new health visiting services through action research: an analysis of process. *Journal of Advanced Nursing*, 30(4): 965-974.

Cowley, Sarah, Bergen, A., Young, K. & Kavanagh A. (2000a) Generalising to theory: The use of multiple case study design to investigate needs assessment and quality of care in community nursing. *International Journal of Nursing Studies*, 37: 219-229.

Cowley, Sarah, Bergen, A., Young, K. & Kavanagh, A. (2000b) A taxonomy of needs assessment, elicited from a multiple case study of community nursing education and practice. *Journal of Advanced Nursing*, 31: 126-134.

Crichton, Anne (1981) Development and rehabilitation policies in Britain, Canada and Australia: A comparison. In G.L. Albrecht, ed. *Cross National Rehabilitation Policies: A Sociological Perspective*. Sage Books, London. pp. 157-84.

Culley, Lorraine (1996) A critique of multiculturalism in health care: The challenge for nurse education. *Journal of Advanced Nursing*, 23: 564-70.

Culley, Lorraine (1997) Ethnicity, health and sociology in the nursing curriculum. *Social Sciences in Health*. 3(1): 28-40.

Curtis, S. & Taket, A. (1996) *Health and Societies: Changing Perspectives*. Arnold, London.

Curtis, S. & Rees Jones (1998) Is there a place for geography in the analysis of health inequality? In Mel Bartley, David Blane & George Davey Smith, eds. *The Sociology of Health Inequalities*. Blackwell Publishers, Oxford. pp. 85-112.

Davey Smith, G. (1999) Poverty across the life-course and health. In Gordon, David, Shaw, M., Dorling, D. & Davey Smith, G. eds. (1999) *Inequalities in Health: The evidence. The evidence presented to the Independent Inquiry into Inequalities in Health, chaired by Sir Donald Acheson.* The Policy Press, Bristol. pp. 76-86.

Davies, J.K. & Macdonald, G. (1998) Beyond Uncertainty: Leading health Promotion into the twenty-first century. In J.K. Davies and G. Macdonald, eds. *Quality, evidence and effectiveness in health promotion. Striving for certainties*. Routledge, London.pp. 207-216.

Dennehey, A. (1998) Keeping mum: the condition of working class women in late 20th century England. Unpublished doctoral thesis, University of Bristol.

Dickert, N. & Grady, C. (1999) What's the price of a research subject? Approaches to payment for research participation. *New England Journal of Medicine*, 341(3): 198-203.

Dion,K.L., Dion, K. k. & Pak, A.W. (1992) Personality based hardiness as a buffer for discrimination related stress in members of Toronto's Chinese community. *Canadian Journal of Behavioural Science*, 24(4): 517-36.

Dirks, Nicholas, Eley, G. & Ortner, Sherry, Eds (1994) *Culture/Power/History: A Reader in Contemporary Social Theory*. Princeton, Princeton University Press.

Dohrenwend, B.P., Levav, I., Shrout, P.E., Schwartz, S., Naveh, G., Link, BB., Skodol, A. & Stueve, A. (1992) Socioeconomic status and psychiatric disorders: the causation-selection issue. *Science*, 255: 946-952.

Donovan, Jenny (1986) *We Don't Buy Sickness, It Just Comes: Health Illness and Health Care in the Lives of Black People in London*. Gower, Aldershot.

Douglas, J. D., ed. (1970) *Understanding everyday life, toward the reconstruction of sociological knowledge*. Aldine Publ., Chicago.

Douglas, M. (1973) *Rules and Meanings: The Anthropology of Everyday Knowledge*. Penguin, Hammondsworth.

Dowling, Monica (1999) Social exclusion, inequality and social work. *Social Policy and Administration*, 33(3): 245-261.

Dyck, I., Lynam, M.J. and Anderson, J.M. (1995) Women talking: Creating knowledge through difference in cross-cultural research. *Women's Studies International Forum*, 18(5-6): 611-26.

Eckersley, R. & Dear, K. (2002) Cultural correlates of youth suicide. *Social Science & Medicine*, 55: 1891-1904.

Edwards, Rosalind (1990) Connecting method and epistemology. *Women's Studies International Forum*, 13(5): 477-90.

Eisenberg, L. & Kleinman, A. (1980) Clinical Social Science. In L. Eisenberg & A. Kleinman, eds. *The Relevance of Social Science for Medicine*. D.Reidel Publishing, Boston. pp. 1-23.

Evans, R.G. (1984) *Strained Mercy: The Economics of Canadian Health Care*. Toronto: Butterworths.

Evans, Robert G. (1992) Canada: The Real Issues. In William Hsiao & James Morone, eds, *Comparative Health Policy. Journal of Health Politics Policy and Law*, 17(4): 739-62.

Evans, R.G., Barer, M.L. & Marmor, T.R., eds. (1994) *Why are some people healthy and others not? The determinants of health of populations*. Aldine de Gruyter, New York.

Feinstein, Jonathan, S. (1993) The relationship between Socioeconomic status and health: A review of the literature. *The Milbank Quarterly,* 71(2): 279-322.

Fenton, Steve & Charsley, Katharine (2000) Epidemiology and sociology as incommensurate games: Accounts from the study of health and ethnicity. *Health*, 4(4):pp. 403-25.

Fernandez-Kelly, M.P. (1995) Social and cultural capital in the urban ghetto: Implications for the economic sociology of immgration. In A. Portes ed. *The Economic Sociology of Immigration*. Russell Sage, New York. pp. 213-47.

Finch, J. (1989) *Family obligations and social change.* Polity Press, Cambridge.

Foltz, A.M. (1995) The policy process. In Katja Janovsky, ed. *Health Policy and Systems Development. An Agenda for Research.* WHO Geneva. pp. 207-33.

Frank, J.W. & Mustard, J.F. (1994) The determinants of health from a historical perspective. *Daedalus*, 123(4): 1-20.

Freire, Paulo (1970) *Pedagogy of the Oppressed.* Seabury Press, New York.

Freire, Paulo (1998) *Pedagogy of Hope: Reliving Pedagogy of the Oppressed.* Continuum, New York.

Friedson, E. (1970) *The profession of medicine: A study of the sociology of applied knowledge.* New York, Harper Row.

Frière, Marlinda (1993) Mental health, culture, children and youth. In R. Masi, L. Mensah & K. McLeod, eds. *Health and cultures exploring the relationships*. vol. 2. Mosaic Press, Oakville.

Garfinkel, H. (1973) Background expectancies. In Mary Douglas, ed. *Rules and meanings: the anthropology of everyday knowledge*. Penguin Education, Hammondsworth.

Geertz, C. (1983) *Local Knowledge: Further Essays in Interpretive Anthropology*. Basic Books Inc., New York.

Giddens, A. ed (1974) *Positivism and Sociology*. Heinemann, London.

Giddens, A. (1984) *The Constitution of Society: Outline of the Theory of Structuration.* University of California Press, Los Angeles.

Giddens, A. (1991) *Modernity and Self-Identity. Self and Society in the Late Modern Age.* Stanford University Press, Stanford.

Giddens, A. (1993) *New Rules of Sociological Method.* Stanford University Press, California. 2nd ed.

Giddens, A. (1997) *Sociology.* Polity Press, Cambridge. 3rd ed.

Gilmore, A., McKee, M. & Rose, R. (2002) Determinants of and inequalities in self-perceived health in Ukraine. *Social Science & Medicine*, 55: 2177-88.

Gilson, Lucy (1998) In defence and pursuit of equity. *Social Science & Medicine,* 47(12): 1981-86.

Goddard, Maria & Smith, P. (2001) Equity and access to health care services: Theory and evidence from the UK. *Social Science & Medicine*, 53: 1149-62.

Good, Byron & Good, M.J.D. (1980) The meaning of symptoms: A cultural hermeneutic model for clinical practice. In L. Eisenberg & A. Kleinman (eds) *The Relevance of Social Science for Medicine.* D. Reidel Publ., Boston: 165-96.

Gordon, Colin, ed. (1980) *Power Knowledge: Selected Interviews and other writings 1972-77 by Michel Foucault.* Pantheon Books, New York.

Gordon, David, Shaw, M., Dorling, D. & Davey Smith, G. eds. (1999) *Inequalities in Health: The evidence.* The evidence presented to the Independent Inquiry into Inequalities in Health, chaired by Sir Donald Acheson. The Policy Press, Bristol.

Grad, R. (1999) Healthcare Reform in Canada: Is there room for efficiency? *Health Law in Canada*, 20(2): 17-30.

Graham, Hilary (1984) *Women, Health & Family, Brighton*, Wheatsheaf Books.

Graham, Hilary (1993) *Hardship and Health in Women's Lives.* Harvester Wheatsheaf London.

Graham, H. (2000) Socio-economic change and inequalities in men and women's health in the U.K. In E. Annandale & K. Hunt (2000) *Gender Inequalities in Health.* Open University Press, Buckingham. pp. 90-122.

Graham, H. (2002) Building an inter-disciplinary science of health inequalities: the example of lifecourse research. *Social Science & Medicine*, 55: 2005-16.

Gray, Gwendolyn (1991) *Federalism and health policy: The development of health systems in Canada and Australia.* University of Toronto Press, Toronto.

Grenfell, M. & James, D., with Hodkinson, P., Reay, D. & Robbins, D.(1998) *Bourdieu and Education: Acts of Practical Theory.* Falmer Press, London.

Guba, Egon, G. & Lincoln, Yvonna, S. (1994) Competing paradigms in qualitative research. Chapter 6 in Norman Denzin & Yvonna Lincoln eds. *Handbook of Qualitative Research.* Sage, London. pp. 105-117.

Haan, Mary, Kaplain, George, Camacho, T. (1987) Poverty and Health: Prospective Evidence from the Alameda County Study. *American Journal of Epidemiology.* 125(6): 989-998.

Hall, Joanne, M. & Stevens, Patricia (1991) Rigor in feminist research. *Advances in Nursing Science*, 13(3): 16-29.

Hall, Stuart (1990) Cultural identity and diaspora. In J. Rutherford, ed. *Identity: community, culture, difference*. Lawrence & Wishart, London.

Hall, Stuart (1996a) When was 'The Post Colonial?'. Thinking at the Limit. In Iain Chambers, Lidia Curti, eds. *The Post-Colonial Question. Common Skills Divided Horizons*. Routledge, London. pp. 212-260.

Hall, Stuart (1996b) What is this 'black' in black popular culture? In D. Morley & Juan-Hsing Chen, eds. *Stuart Hall: Critical Dialogues in Cultural Studies*. Routledge, London. pp. 465-475.

Hamilton, N. & Bhatti, T. (1996) *Population health promotion: An integrated Model of Population Health and Health Promotion.* Report for the Health Promotion Development Division of Health Canada. 4th Floor, Jeanne Mance Building, Tunney's Pasture, Ottawa, Ont. K1A 1B4

Hardey, Michael (1998) *The Social Context of Health.* Health Psychology Series. Open University Press, Buckingham.

Harvey, Lee (1990) *Critical Social Research.* Unwin Hyman, London.

Helman, Cecil (2000) *Culture, Health and Illness: An Introduction for Health Professionals*. 4th ed. Butterworth Heinemann, Oxford.

Heron, John & Reason, P. (1997) A Participatory Inquiry Paradigm. *Qualitative Inquiry*, 3(3): 274-94.

Higgs, Paul & Scambler, Graham (1998) Explaining health inequalities: How Useful are concepts of social class? Chapter 5 in Graham Scambler & Paul Higgs, eds. *Modernity, Medicine and Health: Medical Sociology towards 2000.* Routledge, London, pp. 84-99.

Hillier, Sheila (1997) The health and health care of Ethnic Minority Groups. In G. Scambler (ed). *Sociology as Applied to Medicine.* W.B. Saunders, London. pp. 136-47.

Hillier, S. & Kelleher, D. (1996) Considering culture, ethnicity and the politics of health. In D. Kelleher & Sheila Hillier, eds. (1996) *Researching Cultural Differences in Health.* Routledge, London. pp. 1- 10.

Hillier, Sheila & Scambler, G. (1997) Women as Patients and Providers. In G. Scambler (ed). *Sociology as Applied to Medicine.* W.B. Saunders, London. pp. 121-134.

Hodgkinson, P. (1998) Career Decisions of Youth. In M.Grenfell & D. Janes with P. Hodgkinson, D. Reay & D. Robbins. eds. *Bourdieu and Education: Acts of Practical Theory*. Falmer Press, London.

hooks, bell (1984) *Feminist theory: From margin to centre.* South End Press, Boston.

Hutton, V. (2000) Parliamentary Speech on Children's Social Services - 3 February, 2000. Quality Protects: Transforming Children's Services. http://www.doh.gov.uk/speeches/indes.htm, 03/16/00.

Hseih, C.C. & Pugh, M.D. (1993) Poverty, income inequality and violent crime: a meta-analysis of recent aggregate case studies. *Criminal Justice Review*, 18: 182-202.

Hsiao, W.C. & Morone, James eds. (1992) *Comparative Health Policy*. Special Issue of the *Journal of Health Politics, Policy and Law.* 17(4).

Hsiao, W.C. (1992) Comparing health care systems: What nations can learn from one another. *Journal of Health Politics, Policy and Law.* 17(4): 613-636.

Ingram, David (1987) *Habermas and the Dialectic of Reason*, Yale University Press, New Haven.

Jacobson, B. (1999) Tackling inequalities in health and healthcare – the role of the NHS. In D.Gordon, Mm. Shaw, D. Dorling & G. Davey Smith, eds. *Inequalities in Health: The evidence.* The Policy Press, Bristol, pp. 100-117.

Jiwani, Y. Janovicek, S. & Camereon, A (2002) *The girl child and violence prevention: A review of three areas.* Vancouver, BC, FREDA Centre.

Joshi, H. & Carter, B. (1984) The role of labour in the creation of a racist Britain. *Race & Class* (25):3.

Jowell, Tessa (1997) Public health strategy speech by Minister of Public Health Tessa Jowell, 7 July, l997 DoH Press Release, H97 157.

Karlsen, S., Nazroo, J. & Stephenson, R. (2002) Ethnicity, environment and health: putting ethnic inequalities in health in their place. *Social Science & Medicine*, 55: 1647-61.

Kawachi I., & Kennedy, B. (1997) Health and cocial cohesion: Why care about income inequality? *British Medical Journal*, 314:; 1037-40.

Keen, Justin & Packwood, Tim.(2000) Using case studies in health services & policy research. In Catherine Pope & Nicholas Mays, eds. *Qualitative Research in Health Care.* 2nd ed. BMJ Books, London. pp. 50-58.

Kelleher, D. (1996) A defence of the use of the terms 'ethnicity' and 'culture'. In D. Kelleher & Sheila, Hillier eds. (1996) *Researching Cultural Differences in Health.* Routledge, London. pp. 70-90.

Kelleher, D. & Hillier, Sheila, eds. (1996) *Researching Cultural Differences in Health.* Routledge, London.

Kempson, E., Bryson, A. & Rawlingson, K. (1994) *Hard times? How Poor Families Make Ends Meet.* Policy Studies Institute, London.

Khanlou,N., Beiser, M., Cole,E., Friere, M., Hyman, I. & Kilbride, D.M. (2002*) Mental Health Promotion Among Newcomer Female Youth: Post-Migration Experiences and Self Esteem.* Ottawa, Policy Reseach Directorate, Status of Women Canada.

Killen, M., Lee-Kim, J., McGlothlin, H. & Stangor, C. (2002) *How children and adolescents evaluate gender and racial exclusion.* Monographs of the Society for Research in Child Development. Serial No. 271, vol. 67(4).

Kingdom, John (1996) The United Kingdom. In Ann Wall ed. *Health Care Systems in Liberal Democracies.* London, Routledge: 127-161.

Kirmayer, L(1988) Mind and Body as Metaphors: Hidden values in Biomedicine. In M. Lock & D. Gordon, eds. *Biomedicine Examined.* Kluwer, London. Pp. 57-93.

Klein, Rudolph (1995) *The New Politics of the NHS.* 3rd ed. Longman House, Harlow.

Kleinman, A. (1978) Concepts and a model for the comparison of medical systems as cultural systems. *Social Science and Medicine*, 12: 85-93.

Kuh, D., Hardy, R., Rodgers, B. & Wadsworth, M. (2002) Lifetime risk factors for women's psychological distress in midlife. *Social Science & Medicine*, 55: 1957-73.

Lather, Patricia (1991) *Getting Smart: Feminist Research and Pedagogy with/in the Postmodern.* Routledge, London.

Lee, Harvey (1990) *Critical Social Research.* Unwin Hyman, London.

Li, P. (1988) *Ethnic inequality in a Class Society.* Toronto: Thompson Educational Publishing.

Lillie-Blanton, M. & Laveist, T. (1996) Race/ethniticy, the social environment and health. *Social Science and Medicine*, 43(1):83-91.

Lindbladh, Eva, Lytkens, Carl Hampus, Hanson, Bertil & Ostergren, P.O. (1998) Equity is out of fashion? An essay on autonomy and health policy in the individualized society. *Social Science and Medicine,* 46(8): 1017-25.

Lincoln, Y. (1995) Emerging criteria for quality in Qualitative and Interpretive Research. *Qualitative Inquiry*, 1(3): 275-289.

Lomas, Jonathan (1998) Social Capital and Health: Implications for Public Health and Epidemiology. *Social Science and Medicine*, 47(9): 1181-88.

Lomas, Jonathan & Contandrioupoulos, A. P. (1994) Regulating Limits to Medicine: Towards Harmony in Public and Self Regulation. In R.G. Evans, M.L. Barer & T. Marmor, eds. *Why are some people healthy and others not? The Determinants of Health of Populations.* Aldine De Gruyter, New York. pp. 253-283.

Lynam, M.J. (1985) Support networks of immigrant women. *Social Science and Medicine*, 21(3): 327-33.

Lynam, M. J. (1990) Examining support in context: A redefinition from the cancer patient's perspective. *Sociology of Health and Illness*, 12(2): 169-94.

Lynam, M.J. (1992) Parent network in pediatric oncology: Supportive or Not? *Cancer Nursing*, 10(4): 207-216.

Lynam, M.J. (1995) Supporting one another: the nature of family work when a young adult has cancer. *Journal of Advanced Nursing*, 22: 116-125.

Lynam, M.J. Henderson,A. Browne, A. Smye, V. Semeniuk, P. Blue, C. Singh, S. & Anderson, J. (2003) Health care restructuring with a view to equity and efficiency: Reflections on unintended consequences. *Canadian Journal of Nursing Leadership 16(1): 112-140..*

Lynam, M.J: & Tenn, L. (1986) Adolescent communication: Understanding its dynamics and fostering its development. *Nursing Papers*, 18(1): 67-76.

Lynam, M.J. & Tenn, L. (1989) Communication: a tool for the negotiation of independence in families with adolescents. *Journal of Advanced Nursing,* 14: 653-660.

Lynam, M.J. & Young R. (2000) Towards the creation of a culturally safe research environment. *Health*, 4(1):5-23.

Lynam, M.J., Gurm, B. & Dhari, R. (2000) Indo-Canadian women's health in the perinatal period. *Canadian Nurse*, 96(4): 18-24.

Lynam, M.J. & Dhari, R. (1991) An examination of processes influencing the ways family caregivers draw upon resources of the formal and informal health care system.UBC - Social Sciences and Humanities Grant.

Lynam, M.J. & Young, R.A. (2002) Empowerment, Praxis and Action Theory in Health Promotion Research. In L. Valach, R. Young & Lynam, M.J , *Action Theory: A Primer for Health Research.* Praeger Publishers. Westport, pp. 123 -138.

Macbeth, Helen & Shetty, Prakash, eds. (2001) *Health and Ethnicity.* Taylor & Frances, London.

MacIntyre, Sally (1997) The Black Report and beyond: What are the issues? *Social Science and Medicine*, 44(6): 723-45.

Mares, Penny, Henly, A. & Baxter, Carol (1985) *Health Care in Multiracial Britain.* Health Education Council, National Extension College, Cambridge.

Marmor, T., Barer, M. & Evans, R.G. (1994) The determinants of a population's health: What can be done to improve a democratic nation's health status? In R.G. Evans, M.C. Barer & T.R. Marmor, eds. *Why are some people healthy and others not? The Determinants of Health of Populations*, Aldine de Gruyter, New York. pp. 217-230.

Marmot, M., Ryff, C., Bumpass, L., Shipley, M. & Marks, N. (1997) Social inequalities in health: Next questions and converging evidence. *Social Science & Medicine*, 44(6): 901-10.

Marmot, Michael & Wilkinson, Richard, eds. (1999) *Social Determinants of Health.* Oxford University Press, Oxford.

Maslin-Prothero, Sian (1994) Race and Policy. In Pippa Gough, Sian Maslin-Prothero, & Abigail Masterson eds. Introduction by Jane Robinson. *Nursing and Social Policy: Care in Context.* Butterworth Heinemann. pp. 170-192.

McKeever, Patricia (1994) Between women: Nurses and family caregivers. *Canadian Journal of Nursing Research*, 26(4): 15-21.

McKnight, Janet & Van Dover, Leslie (1994) Community as Client: A Challenge for Nursing Education. *Public Health Nursing*, 11(1): 12-16.

Meilicke, Carl & Storch, Janet (1980) Eds. *Perspectives on Canadian Health and Social Services Policy: History and Emerging Trends*. Health Administration Press, Ann Arbor, Michigan.

Morgan, David, C. (1988) Focus Groups as Qualitative Research, *Qualitative Research Methods.* Sage Publications, Beverly Hills.

Morgan, Lynn (1993) *Community Participation in Health: The Politics of Primary Care in Costa Rica.* Cambridge University Press, Cambridge.

Morse, J. M. (1985) Quantitative and Qualitative Research: Issues in Sampling. In P. Chinn, ed. *Nursing Research Methodology: Issues and Implementation.* Aspen Publishers, Rockville; Md. pp.181-193.

Munhall, Patricia & Oiler, C. (1993) *Nursing Research: A Qualitative Perspective.* 2nd ed. National League for Nursing Press, New York. Pub'n no. 19-2535.

Nast, Heidi, (1994) Women in the field: Critical feminist methodologies and theoretical perspectives. *Professional Geographer*, 46(1): 54-66.

Nazroo, J.Y.(1999) Ethnic Inequalities in Health. In David Gordon, M., Shaw, M., D.Dorling, & G. Davey Smith eds. *Inequalities in Health: The evidence. The evidence presented to the Independent Inquiry into Inequalities in Health*, chaired by Sir Donald Acheson. The Policy Press, Bristol. pp. 155-169.

Nazroo, J.Y. & Davey Smith, George (2001) The contribution of socio-economic position to health differentials between ethnic groups. Evidcence from the U.S. and Britain. In Helen MacBeth & Prakash Shetty, eds.(2001) *Health and Ethnicity*. Taylor and Francis, London. pp.41-58.

Noël, Lise (1994) *Intolerance: A general survey.* McGill-Queens University Press, Montreal.

Noh, S., Beiser,M., Kasper, V., Hou, F., & Rummens, J. (1999) Discrimination and emotional well-being: Perceived racial discrimination, depression and coping: a study of Southeast Asian refugees in Canada. *Journal of Health and Social Behaviour*, 40(3): 193-207.

Ontario (1995) *Strengthening Voices: Ministry of Health Anti-Racism Strategy.* Government of Ontario Ministry of Health, Queen's Printer for Ontario, Toronto. Cat. # 4228723.

Oakley, A. (1994) Introduction In A.. Oakley. & S. Williams, eds. *The Politics of the Welfare State.* UCL Press, London. pp. 1-17.

Ostberg, V. (2003) Children in classrooms: peer status, status distribution and mental well-being. *Social Science & Medicine*, 56: 17-29.

Ovretvert, John (1997) *Comparative health research.* Nordic School of Public Health, Goteborg, Sweden.

Pahl, J. (1989) *Money and marriage.* Macmillan, Basinstoke.

Phipps, Shelley (1999) *An International Comparison of Policies and Outcomes for Young Children.* Canadian Policy Research Network (C.P.R.N.) Study No. F/05. C.P.R.N, Ottawa.

Porter, Sam (1998) *Social Theory and Nursing Practice*, MacMillan Press, London.

Portes, A. (1998) Social Capital: Its Origins and Applications in Modern Sociology. *Annual Reviews Sociology*, 24: 1-24.

Power, C., Manor, O. & Fox, J. (1991) *Health and class: The early years.* London: Chapman and Hall.

Power, C., Hertzman, C., Matthews, S. & Manor, O. (1997) Social differences in health: Life-cycle effects between ages 23 and 33 in the 1958 British birth cohort. *American Journal of Public Health*, 87(9): 1499-503.

Power, C., Stansfeld, S., Matthews, S., Manor, O. & Hope, S. (2002) Childhood and adulthood risk factors for socio-economic differentials in psychological distress: evidence from the 1958 British birth cohort. *Social Science & Medicine*, 55: 1989-2004.

Prout, Alan (1999) Children: A Suitable Case for Social Exclusion? Centre for Public Policy Research Annual Lecture. Kings College London, May 29.

Putnam, R.D. (1995) Tuning in, tuning out: The strange disappearance of social capital in America. *Political Science and Policy.* Dec: 664-83.

Putnam, R.D. (1993) The prosperous community: Social Capital and Public Life. *American Prospect*, 13: 35-42.

Radley, A. (1988) *Prospects of heart surgery: psychological adjustment to coronary bypass grafting.* Springer-Verlag, London.

Radley, A. (1994) *Making Sense of Illness.* Sage, London.

Radley, A. & Billig, M. (1996) Accounts of Health and Illness: Dilemmas and Representations. *Sociology of Health and Illness*, 18(2): 220-40.

Reason, P. & Heron, J. (1995) Co-operative inquiry. In R. Harre, J. Smith, & L. Van Langenhove, eds. *Rethinking in psychology.* Sage: London.

Reay, Diane (1996a) Dealing with difficult differences: Reflexivity and Social Class in Feminist Research. *Feminism and Psychology*, 6(3): 443-56.

Reay, Diane (1996b) Insider Perspectives or Stealing the words out of Women's Mouths: Interpretation and the Research Process. *Feminist Review*, 53: 57-73.

Reay, Diane (1998a) *Class work: Mothers' Involvement in their Children's Primary Schooling*. UCL Press, London.

Reay, Diane (1998b) Cultural reproduction: Mothers' Involvement in their Children's Primary Schooling. In M. Grenfell & D. James eds. *Bourdieu and Education: Acts of Practical Theory*. Falmer Press, London. pp. 55-71.

Reay, Diane (1999) Pierre Bourdieu: The Theory of Practice or the Practice of Theory? Paper presented at the Critical Thinkers Day, School of Education, Kings College London, Dec. 10.

Reed, Ján & Roskell Payton, V. (1997) Focus Groups: Issues of analysis and interpretation. *Journal of Advanced Nursing*, 26: 765-771.

Reimer Kirkham, S. & Anderson, J.M. (2002) Postcolonial Nursing Scholarship: From Epistemology to Method. *Advances in Nursing Science*, 25(1): 1-17.

Reimer Kirkham, S., Smye, V., Tang, S. & Anderson, J., Blue, C., Browne, A., Coles, R., Dyck, I., Henderson, A., Lynam, M.J., Perry, J., Semeniuk, P. & Shapira, L. (2002). Rethinking Cultural Safety while waiting to do fieldwork: Methodological Implications for Nursing Research. *Research in Nursing and Health*, 25: 222-32.

Reinhardt, Uwe (1992) The United States: Breakthroughs and Waste. In William Hsiao & James Morone, eds, *Comparative Health Policy. Journal of Health Politics Policy and Law*, 17(4): 637-666.

Richards, Lyn (1999) *Using N*VIVO in Qualitative Research.* Qualitative Solutions and Research, Bundoora.

Rivett, Geoffrey (1997) *From Cradle to Grave: Fifty years of the N.H.S.* The King's Fund, London.

Robinson, Jane (1999) Researching National Health Service reform in the 1980's: issues of substance and method. In Jane Robinson, M. Aris, J. Latimer, & M. Traynor, *Interdisciplinary Perspectives on Health Policy and Practice: Competing interests or complementary interpretations?* Churchill Livingstone, London. pp. 33-51.

Robinson, Jane, Aris, M., Latimer, J. & Traynor, M. (1999) *Interdisciplinary Perspectives on Health Policy and Practice: Competing interests or complementary interpretations?* Churchill Livingstone, London.

Robinson, J. & Elkan, R. (1996) *Health Needs Assessment: Theory and Practice.* Churchill Livingstone, Edinburgh.

Rodriques, E. (2002) Marginal employment and health in Britain and Germany: does unstable employment predict health? *Social Science & Medicine*, 55: 963-979.

Rogers, A., Adamson,J. & McCarthy, M. (1997) Variations in health behaviours among inner city 12 year olds from four ethnic groups. *Ethnicity and Health*, 2(4): 309-16.

Roos, N.P., Brownell, M., Shapiro, E. & Roos, L. (1998) Good news about difficult decisions: The Canadian approach to hospital cost control. *Health Affairs*, 17(5): 239-46.

Roos, N. & Mustard, C. (1997) Variation in health and health care use by socioeconomic status in Winnipeg, Canada: Does the system work well? Yes and No. *The Milbank Quarterly*, 75(1): 89-111.

Rumbaut, R.G. (1994) The crucible within: ethnic identity, self-esteem, and segmented assimilation among children of immigrants. *International Migration Review*. 28: 748-94.

Sacker, A., Schoon, I. & Bartley, M. (2002) Social inequality in educational achievement and psychosocial adjustment throughout childhood: magnitude and mechanisms. *Social Science & Medicine*, 55: 863-80.

Sandelowski, M. (1994) Notes on Transcription. *Research in Nursing and Health.* 17: 311-314.

Sandelowski, M. (1995) Sample size in qualitative research. *Research in Nursing and Health,* 18: 179-83.

Sandelowski, M. (1996) One is the liveliest number: The case orientation of qualitative research. *Research in Nursing and Health.* 19: 525-29.

Saywell, John T. (1968) Introduction to Pierre Elliot Trudeau, *Federalism and the French Canadians*. Toronto, MacMIllan of Canada: vii - xiii.

Scambler, G. ed. (1997) Sociology as Applied to Medicine. 4th ed. W.B. Saunders, London.

Scambler, Annette (1998) Gender, Health and the Feminist debate on Post Modernism. In G. Scambler & P. Higgs, eds. *Modernity, Medicine and Health.* Routledge, London. pp. 100-124.

Schutz, Alfred (1973) *Collected papers I: The Problem of Social Reality*. 4th ed. Martinus Nijhoff, The Hague.

Schutz, Alfred (1970) *On Phenomenology and Social Relations: Selected Writings*. The University of Chicago Press, Chicago.

Shaw, Mary, Dorling, D. & Davey Smith, G. (1999) Poverty, social exclusion and minorities. In Michael Marmot & R.G. Williamson, eds. *Social Determinants of Health.* Oxford University Press, Cambridge. pp. 211-238.

Silvera, Mike & Kaposi, Rukshana (2000) *Health Advocacy for Minority Ethnic Londoners. Putting Services on the Map?* King's Fund, London.

Silver, E., Mulvey, E.P. & Swanson, J. (2002) Neighbourhood structural characteristics and mental disorder: Faris and Dunham Revisited. *Social Science & Medicine*, 55: 1457-70.

Smaje, Chris (1995) *Health, 'Race', & Ethnicity: Making Sense of the Evidence.* King's Fund Institute, London.

Smith, D. (1976) *The facts of racial disadvantage: A National Survey*. PEP. (as cited in the Black Report).

Smith, D.E. (1987a) Institutional ethnography: A feminist research strategy. In Dorothy E. Smith, ed. *The Everyday World as Problematic: A Feminist Sociology*. Toronto: University of Toronto Press: 151-79.

Smith, D.E. (1987b) *The Everyday World as Problematic: A Feminist Sociology*. University of Toronto Press, Toronto.

Smith, D.E. (1990) *The conceptual practices of power: A feminist sociology of knowledge*. University of Toronto Press, Toronto.

Spurgeon, Peter (1998) ed. *The New Face of the NHS*. 2nd ed. Royal Society of Medicine Press, London.

Stack, C. (1974) All our kin. Harper Row, New York.

Stroik, S. & Jensen, J. (1999) *What is the best policy mix for Canada's young children?* C.P.R.N. Study no. F109; Renouf Publishers, Ottawa.

Stubbs, P. (1993) "Ethnically sensitive" or "anti-racist"? Models for health research and service delivery. In W.I.U. Ahmad, (ed). *'Race' and Health in Contemporary Britain.* Open University Press, Buckingham. pp. 43-47.

Sullivan, M. (1989) *Getting Paid: Youth Crime and Work in the Inner City*. Cornell University Press, Ithaca, N.Y.

Taylor, David ed. (1996) *Critical Social Policy: A Reader, Social Policy and Social Relations*. Sage, London.

Taylor, Steve, ed. (1999) *Sociology Issues and Debates*. MacMillan Press, London.

Taylor, J. & Jackson, B. (1990) Factors affecting alcohol consumption in black women, Part II. *The International Journal of Addictions*, 25(12): 1415-27.

Thompson, Sonia (1998) Paying respondents and informants. *Social Research Update,* 14: 30 January: 7 pages. Internet Journal published by Department of Sociology: University of Surrey, Guildford, UK.

Tomes, E., Brown, A. Semenya, K. & Simpson, J. (1990) Depression in black women of low socioeconomic status: psychological factors and nursing diagnosis. *Journal of National Black Nurses Association*. 4: 37-46.

Traynor, M. (1999) Introduction. In J. Robinson, M. Avis, J. Latimer & M. Traynor, eds. *Interdisciplinary Perspectives on Health Policy and Practice. Competing interests or complementary interpretations?* Churchill Livingstone, London: pp. 26-28.

Townsend, Peter & Davidson, Nick eds. (1992) *Inequalities in Health. The Black Report* (Sir Douglas Black, Professor, J.N. Morris, Dr. Cyril Smith, Professor Peter Townsend Edited by Peter Townsend and Nick Davidson: 31-213) *and The Health Divide*, Margaret Whitehead: 219-400. Penguin Books, London.

Trudeau, Pierre Elliot (1968) *Federalism and the French Canadians*. MacMillan of Canada, Toronto.

Twaddle, Andrew C. (1996) Health system reform - Toward a framework for international comparisons. *Social Science and Medicine.* 43(5): 637-54.

Valach, L., Young, R. & Lynam, M.J. (1996) Family Health Promotion Projects: An Action Theoretical Perspective. *Journal of Health Psychology*. 1(1): 49-63.

Valach, L., Young, R. & Lynam, M.J. (2002). *Action Theory A Primer for Applied Research in the Social Sciences*. Praeger, Westport.

Vancouver-Richmond Health Board (VRHB) (no date) *Inaugural Health Plan Summary.* V.R.H.B., Vancouver.

VRHB (2000, June) *Framework for Diversity: Diversity in Health Services, Human Rights and Employment Equity Initiatives in the Vancouver-Richmond Health Board Region*, V.R.H.B., Vancouver,June.

Walby, S. (1997) *Gender Transformations*. Routledge, London.

Walker, Alan & Walker, Carol (1997) Eds. *Britain Divided: The growth of social exclusion in the 1980s and 1990s*. CPAG, London.

Walker, Alan (1998). Introduction: The strategy of Inequality. In A. Walker & C. Walker, eds. *Britain Divided: The growth of social exclusion in the 1980s and 1990s.* CPAG, London: 1-31.

Walker, A. (1983) Care for elderly people; a conflict between women and the state. In J. Finch and D. Groves eds. *A Labour of love: women work and caring.* Routledge & Kegan, London.

Wall, Ann (1996) ed. *Health Care Systems in Liberal Democracies*. Routledge, London.

Wallerstein, Nina (1992) Powerlessness, Empowerment & Health: Implications for health promotion programmes. *International Journal of Health Promotion.* Jan-Feb, 6(3): 197-205.

Weis, L. (1985) Between two worlds: Black students in an urban community college. In M. Apple & L. Weis eds (1985) *Ideology and Practice in Schooling.* Temple University Press, Philadelphia.

Werner, E (1989) High risk children in young adulthood: A longitudinal study from birth to 32 years. *American Journal of Orthopsychiatry,* 59(1): 72-81.

West, P. (1988) Inequalies? Social Class Differentials in health in British youth. *Social Science & Medicine*, 27(4): 291-6.

West, P. & Sweeting, H. (1996) Nae job nae future: young people and health in a context of unemployment. *Health and Social Care in the Community*, 4(1): 50-62.

West, P. (1999) Youth. In David Gordon, Mary Shaw, Daniel Dorling and George Davey Smith, eds. *Inequalities in Health: The Evidence.* The evidence presented to the Independent Inquiry into Inequalities in Healt*h*, chaired by Sir Donald Acheson. The Policy Press, Bristol. pp. 12-22.

Whitehead, Margaret (1992) *The Health Divide.* With the *Black Report,* in *Inequalities in Health,* 2nd Ed. Penguin Books, London.

Whitty, G., Aggleton,P., Gamarikov, E. & Tyrer, P.(1999) Education and health inequalities. In . In Gordon, David, Shaw, M., Dorling, D. & Davey Smith, G. eds. (1999*) Inequalities in Health: The evidence.* The evidence presented to the Independent Inquiry into Inequalities in Health, chaired by Sir Donald Acheson. The Policy Press, Bristol. pp. 138-47.

Wilkinson, Richard G. (1994) The epidemiological transition: from material scarcity to social disadvantage? *Daedalus*, 123(4): 61-78.

Wilkinson, Richard G. (1996) *Unhealthy Societies: The Afflictions of Inequality.* Routledge, London.

Wilkinson, Richard G. (1999) The social environment. In Gordon, David, Shaw, M., Dorling, D. & Davey Smith, G. eds. (1999) *Inequalities in Health: The evidence.* The evidence presented to the Independent Inquiry into Inequalities in Health, chaired by Sir Donald Acheson. The Policy Press, Bristol. pp. 68-75.

Williams, Fiona (1989) *Social Policy: A Critical Introduction.* Polity Press, Cambridge.

Williams, Fiona (1996) Racism and the discipline of social policy: A critique of welfare theory. In David Taylor, ed. *Critical Social Policy: A Reader.* Sage Publications, London. pp. 48-76.

Williams, Gareth & Popay, Jennie (1994) Researching the people's health: Dilemas and opportunities for social scientists. In Jennie Popay, & Gareth Williams Eds. *Researching the Peoples' Health.* Routledge, London. pp. 99-114.

Williams, David R. & Williams-Morris, Ruth (2000) Racism and Mental Health: the African American experience. *Ethnicity & Health*, 5(3/4): 243-268.

Woodward, Kathryn, ed. (1997) *Identity and Difference.* Sage, London.

World Health Organization (WHO) (1986) *Ottawa Charter for Health Promotion.* WHO Regional Office, Europe, Copenhagen.

WHO (1997a) Scope and Purpose Document for "New Players for a New Era". Leading Health Promotion into the 21st Century. WHO Organization Conference, Jakarta, Indonesia, 21-25, July 1997.

WHO (1997b) Health Promotion Glossary Document for "New Players for a New Era". Leading Health Promotion into the 21st Century. WHO Organization Conference, Jakarta, Indonesia, 21-25, July 1997.

Young, R. & Lynam, M.J. (1995) Parent-Adolescent Discourse: The study of health promotion from an Action Theoretical perspective. *The Canadian Health Psychologist/Le Psychologue Canadien de la Santé*. 3(1): 17-19.

Young, R., Lynam, M.J., Valach, L., Novak, H., Brierton, I. & Christopher, A. (2001) Joint Actions of Parents and Adolescents in Health Conversations. *Qualitative Health Research*, 11(1): 4-57.

APPENDIX 1

MANAGEMENT OF HEALTH AND ILLNESS IN THE FAMILY: PERSPECTIVES OF FIRST GENERATION WOMEN AND THEIR DAUGHTERS

Protocol for Small Group Discussion

The small group discussions will take place at a community centre familiar to the women. Questions are organized around topic areas. They may be asked in a different order depending upon the ways initial questions are responded to.

Questions are also designed to get at general information and can be responded to with "public" knowledge. That is, participants will be able to respond to the questions in a general way . For example, they may indicate they seek information from their parents, or friends when making a health decision, without having to say what the health decision might be. Or, they should be able to answer without divulging "private" information like, specific health or family issues they are dealing with, or names of organizations or people with whom they interact etc.

Consent:

The purposes of the project and nature of individual involvement will be described as per letter of information & consent. Consent forms will be circulated and read out. Individual's questions (i.e. about the study, confidentiality, commitment etc.) will be answered. Signed consent forms will be collected.

Introduction to the study:

The researcher will introduce herself and provide a brief overview of the background to the project and why it is of interest to her and provide an opportunity for participants to ask questions of her.

Ground rules for the discussion will be outlined. These 'rules' include a request people keep names of persons involved in discussions confidential. Request that only one person speak at a time and indicate that each person will be given an opportunity to respond to each question. The researcher will explain that there are no "right" or "wrong" answers to questions, we are interested in everyone's perspectives.

Getting to know the group: (Groups will include 5 - 7 women)

Women will be invited to introduce themselves to one another and the researcher and indicate how long they have been living in the UK and London, and describe the ages of their children and activities they are involved in their family and or the community. (Could include: family commitments, volunteer roles, work roles, work with voluntary agencies etc.).

Trigger Questions

Women's approaches to learning about the UK and their new community:

When moving to the UK what influenced your decision to live in London? (For example, extended family already lived in London, there were work opportunities, sponsoring agency was in London)

What people or organizations helped you to settle upon arrival in the UK in London?

(Depending upon answers may explore whether/how family, voluntary organizations or cultural groups, formal agencies played a role in settlement).

Women's roles in managing-promoting family health:

What do you see as your role in promoting health in the family or managing illness in the family?

What resources do you draw upon when making decisions about family health? (Consider resources within family, community, network of friends, formal system etc.)

How did you learn about the health care system here? (Explore sources of information i.e.is knowledge of health system or health programmes and resources derived mainly from friends, family or via referrals through the system?

Have you faced any difficulties in accessing health services? (Explore barriers such as language, costs, eligibility for services, lack of knowledge of services etc.)

Is there particular information that you think health professionals need in order to work more effectively with women or families in this ethnocultural community?

Explore such topics as:

- Information about the structure of the community or of the family?
- Traditions or practices that might influence timing of interventions or that should be taken into account when providing care.

Perceptions of the role of health care providers in supporting families in dealing with developmental issues (i.e. during adolescence)?

When you have questions about your children's development (physical or social) or wellbeing who do you turn to? (Consider family resources, resources of the community, resources outside of the community, school based resources, health care based resources).

Do you think health care providers (community nurses, family physicians etc.) have a role to play in helping families to deal with developmental issues?

If so, what role?

Perceptions of community role in health care provision:

In some places health professionals try to work in partnership with community groups when deciding what health programmes are needed or when exploring how best to provide services.

Do you think that if health care professionals worked in partnership with the community in developing programmes or resources some of the difficulties or challenges you faced (as noted above) might have been dealt with differently?

(Explore whether there are instances where this has happened, or where they have been invited to work in partnership and what developed).

APPENDIX 2

LETTER OF INFORMATION AND CONSENT

MANAGEMENT OF HEALTH AND ILLNESS IN THE FAMILY: PERSPECTIVES OF FIRST GENERATION WOMEN AND THEIR DAUGHTERS A CROSS NATIONAL STUDY

PRINCIPAL INVESTIGATOR:

M. JUDITH LYNAM, PHD STUDENT IN NURSING AT KING'S COLLEGE LONDON

SUPERVISOR:

DR. SARAH COWLEY, PROFESSOR, KING'S COLLEGE LONDON

PURPOSE:

THE PURPOSE OF THIS RESEARCH IS TO EXPLORE HOW FIRST GENERATION WOMEN, WITH ADOLESCENT DAUGHTERS, DRAW UPON THE RESOURCES OF THE COMMUNITY, PARTICULARLY THEIR INFORMAL NETWORK(S), FOR INFORMATION AND SUPPORT TO MANAGE FAMILY HEALTH AND ILLNESS. SIMILAR INTERVIEWS ARE ALSO BEING UNDERTAKEN WITH FIRST GENERATION WOMEN AND THEIR DAUGHTERS IN CANADA. INFORMATION PROVIDED BY THE WOMEN WILL BE USED TO MAKE RECOMMENDATIONS ABOUT HOW HEALTH CARE SERVICES FOR FIRST GENERATION FAMILIES COULD BE PROVIDED.

STUDY PROCEDURES:

FIRST GENERATION WOMEN, WITH ADOLESCENT DAUGHTERS, ARE INVITED TO PARTICIPATE IN A SMALL GROUP DISCUSSION AND AN INDIVIDUAL INTERVIEW.

- IN THE DISCUSSION WOMEN WILL BE ASKED ABOUT THE WAYS THEY USE THEIR FAMILY, FRIENDS, COMMUNITY ORGANIZATIONS OR FORMAL HEALTH CARE PROGRAMMES TO MANAGE FAMILY HEALTH AND ILLNESS EVENTS. THE DISCUSSION WILL TAKE PLACE AT A COMMUNITY CENTRE AND WILL LAST ABOUT 1.5 HOURS.

- IN THE INTERVIEW THE WOMAN WILL FURTHER DISCUSS THE RESOURCES SHE USES WHEN MAKING HEALTH DECISIONS OR WHEN MANAGING FAMILY ILLNESS. THESE INTERVIEWS WILL BE SCHEDULED AT A TIME CONVENIENT TO THE WOMAN. THE INTERVIEWS WILL LAST ABOUT 1 HOUR.

- EACH WOMAN WILL ALSO ASK HER ADOLESCENT DAUGHTER IF SHE WOULD LIKE TO BE INTERVIEWED BY THE RESEARCHER TO DISCUSS HOW SHE USES FAMILY, FRIENDS, COMMUNITY ORGANIZATIONS TO MEET HER NEEDS FOR HEALTH INFORMATION OR SUPPORT. INTERVIEWS WITH THE DAUGHTER WILL LAST ABOUT 30 MINUTES.

WRITTEN AND VERBAL CONSENT WILL BE OBTAINED FROM EACH WOMAN IN THE SMALL GROUP AND FROM EACH WOMAN AT THE TIME OF THE INDIVIDUAL INTERVIEW. IF THE WOMAN'S DAUGHTER CHOOSES TO PARTICIPATE, SHE WILL ALSO BE ASKED TO SIGN A CONSENT FORM.

THE SMALL GROUP DISCUSSION AND THE INDIVIDUAL INTERVIEWS WILL BE TAPE RECORDED BY THE RESEARCHER. THESE TAPE RECORDINGS WILL LATER BE TYPED OUT BY THE RESEARCHER AND ANALYSED.

CONFIDENTIALITY

ALL NAMES WILL BE REMOVED IN THE TYPED MATERIALS AND CODE NAMES WILL BE ASSIGNED. NO WOMEN OR DAUGHTERS PARTICIPATING WILL BE IDENTIFIED IN THE STUDY MATERIALS OR IN THE PAPERS WRITTEN ABOUT THE STUDY. ALL MATERIALS RELATED TO THE STUDY WILL BE KEPT IN A LOCKED FILE ACCESSIBLE ONLY TO THE RESEARCHER.

COMPENSATION

IN RECOGNITION OF THE TIME INVOLVED IN PARTICIPATING IN THE GROUP AND INDIVIDUAL INTERVIEWS AND TO ACKNOWLEDGE THE COST OF TRANSPORTATION TO THE GROUP DISCUSSION AN HONORARIUM OF £10.00 WILL BE OFFERED TO EACH WOMAN PARTICIPATING AND £5.00 TO EACH DAUGHTER WHO AGREES TO PARTICIPATE.

CONTACT

IF I HAVE ANY QUESTIONS OR DESIRE FURTHER INFORMATION ABOUT THIS STUDY I MAY CONTACT

MS. JUDITH LYNAM AT KING'S COLLEGE LONDON, GRADUATE PROGRAMME IN NURSING BY TELEPHONE AT: .....

ALTERNATIVELY I MAY CONTACT HER SUPERVISOR

DR. SARAH COWLEY, ALSO AT KING'S COLLEGE LONDON, BY TELEPHONE AT: 0171 872 3030

CONSENT

I UNDERSTAND THAT MY PARTICIPATION IN THIS STUDY IS ENTIRELY VOLUNTARY AND THAT I MAY REFUSE TO PARTICIPATE IN, OR WITHDRAW FROM, THE STUDY AT ANY TIME WITHOUT JEOPARDIZING MY CONTINUED USE OF COMMUNITY FACILITIES OR RESOURCES.

THIS CONSENT FORM AND LETTER OF INFORMATION HAS BEEN READ TO ME AND MY QUESTIONS ABOUT THE STUDY HAVE BEEN ANSWERED TO MY SATISFACTION.

I HAVE RECEIVED A COPY OF THIS CONSENT FORM FOR MY OWN RECORDS.

I CONSENT TO PARTICIPATE IN THIS STUDY

_____ _____

SIGNATURE & DATE SIGNATURE OF WITNESS & DATE

<u>MOTHER'S CONSENT FOR DAUGHTER'S PARTICIPATION</u>

I CONSENT/DO NOT CONSENT TO MY DAUGHTER'S PARTICIPATION IN THIS STUDY.

_____ _____

PARENT SIGNATURE & DATE SIGNATURE OF WITNESS & DATE

<u>ADOLESCENT DAUGHTER'S CONSENT/ASSENT</u>

I CONSENT TO PARTICIPATE IN THIS STUDY

_____ _____

ADOLESCENT'S SIGNATURE & DATE SIGNATURE OF WITNESS & DATE

Appendix 3

MANAGEMENT OF HEALTH AND ILLNESS IN THE FAMILY: PERSPECTIVES OF FIRST GENERATION WOMEN AND THEIR DAUGHTERS

Individual Interviews with Mothers

The individual interviews will be scheduled with women who are interested in participating and will be scheduled after the group discussion. Interviews will take place in the women's homes or other places that they might identify as convenient to them.

The purpose of the indivdual interviews is to explore in more depth the women's perspectives of their roles in health promotion and illness management within the family and the resources they draw upon to fulfill their roles in this 'new' socio-cultural context. It will explore in particular, ways they approach meeting the developmental needs of their adolescent daugthers, the challenges they face and the resources they draw upon.

Trigger Questions

1. I am interested in understanding more about how women develop a network of support after they immigrate. Could you tell me about what it was like for you when you first arrived in London/the UK? Who did you turn to for information, or support?

Explore:

Nature of information and support provided.

How she learned about or connected with such resources (i.e. made friends through work, met people through settlement agency, met people through extended family already living in UK)

Difficulties faced if isolated and how these were overcome.

2. Do these people/organizations continue to be helpful to you? In what way?

Appraise women's views of whether support/resources helped them to deal with situational issues or whether they became central ongoing resources.

3. Is it important for you and your family to maintain links with your cultural heritage?

If yes, explore:

What do you, or does your family do to accomplish this?

What challenges do you face in accomplishing this?

4. In my work with immigrant families, many parents tell me that when their children become adolescents they find it particularly difficult to maintain/sustain cultural traditions.

What has your experience been? Is this important for you?

Explore any challenges and strategies/approaches uses to overcome challenges.

5. Adolescence is also a time many parents find challenging.

Are you facing any particular challenges in dealing with your daughter/sons?

What resources/if any do you draw upon to explore ways of dealing with such challenges?

Do you see a role for health care professionals in supporting families/teens?

If yes, Explore the nature of the role.

If no, explore others/other roles, that might be a resource.

6. In some places health professionals try to work in partnership with community groups and parents when deciding what health programmes are needed or when exploring how best to provide services.

Is this something that has happened for you?

If yes explore how.
If no, is this something that might make a difference? In what way?

Appendix 4

MANAGEMENT OF HEALTH AND ILLNESS IN THE FAMILY: PERSPECTIVES OF FIRST GENERATION WOMEN AND THEIR DAUGHTERS

Individual Interviews - with Adolescent Daughters

As this will be my first contact with the daughters I will introduce myself, and the purpose of the research. That is, to understand from adolescent perspective what health or developmental issues they are facing and what resources they draw upon to deal with them.
I will reiterate that information shared will be kept confidential and explain how. I will review the consent form and explain the other parts of the research. That is, the group session, interviews with the mothers and the counterpart study in Canada.

I will invite the adolescent to ask me questions about myself, my work, my life in Canada etc. Why I am interested in these issues and their particular viewpoint.

Trigger Questions

1. Tell me some things about yourself. How you like to spend your time outside of School, interests etc.
Explore how much time spent on own with friends etc. and how much time spent with family doing family focused activities.

2. Many of the teenagers and adolescents I have worked with in the past have talked about the important role friends play in dealing with day to day issues.
Is this the case for you? Can you tell me about your group of friends?
When you're making a decision, do you talk things over with your friends?
What kinds of decisions would these be?
Do your friends ask you for advice, support?

3. Many of the teenagers and adolescents I have worked with in the past have said that it was very important for them to have a good relationship with their parents or other adult family members, but many find this difficult to accomplish.
What kind of relationship would you like with your parents/other extended family?

Expore:

Ways they want their parents/extended family to support them/understand them etc.

Do you involve your parents/extended family in discussions about decisions you are trying to make? If yes, perhaps consider an example. If no, explore why.

4. Are there other types of people or resources (people outside of the friends or family) that you draw upon when making decisions?

Explore: school based resource people, health professionals/nurses/ physicians etc.

5. In some places health professionals try to work in partnership with youth and parents when deciding what health programmes are needed or when exploring how best to provide services.

Is this something that has happened for you?

If yes explore how.

If no, is this something that might make a difference? In what way?

Appendix 5

AN ANALYSIS OF THE INTERFACE BETWEEN THE FORMAL AND INFORMAL SECTORS OF THE HEALTH CARE SYSTEM MANAGEMENT OF HEALTH AND ILLNESS IN THE FAMILY: DEMOGRAPHIC DATA & DATA GATHERING PROFILE

Code Name Assigned: Mother: _____Daughter: _____

Data Gathering Profile

Date of Enrollment in Study: _____

Mother:
Participated in Small Group: A - B - C - D- E Date of Group Discussion: _____

Consent on File: yes / no

Mother Follow-up Interview scheduled: _____ _____

completed: _____

Transcribed: _____Checked against tape:_____Coded: _____Codes entered:_____

Daughter:
Daughter interested in participating? yes/no _____

Consent on File: yes / no

If yes, interview scheduled _____

Interview completed: _____

Transcribed: _____Checked against tape:_____Coded: _____Codes entered:_____

DEMOGRAPHIC DATA con't

Participant Code Names: Mother _____ Daughter _____

Information about participants and family members

Participants:

Mother:

Self Assigned Family role: _____

Age: _____

Languages spoken:_____ Written: _____

Paid & unpaid commitments outside of the family: _____

_____

If working, working in chosen field? _____

Level of Education	Country
University or College graduate	_____
Some University or college	_____
Trade School	___ _____
High School Graduate	_____
Some High School Education	___ _____
Less Than High School Education	_____

Migration:

Migration route to UK / Canada_____

Years in UK _____/ Canada _____: _____

Immigrant _____/ Refugee _____

Migrated as individual _____ Adult Family _____

Dependent Family _____

Sponsoring agency/ family? Y /N /NA _____

Family Work Profile & Financial Status: Mother's viewpoint

Are finances a challenge for the family? _____

How many family members contribute to family income? _____

Are people working in desired employment?_____

Self described health status: _____

Daughter:

Self Assigned Family role: _____

Age: _____

Grade/level in School: _____

Languages spoken:_____ Written: _____

Interests or scheduled activities outside of school_____

_____

Self described health status: _____

Other Family Members Living Together in Home:

Code Name	Family Role	Age	Gender	Language		Yrs in UK/Canada
				speak	write	

Participants' perspective on health of family members:

_____

Extended or other Family Frequency/Nature of Contact

Relationship	Contact with which Family Member	Type of contact (i.e. telephone, visit)	Frequency	
			#weekly	#monthly

Formal and Informal Organizations

Informal/Voluntary Organizations (use services of/offer services to/ participate in activities):

(i.e. church, immigrant serving agency, school based parent group, sports team)

Who in Family _____ Type of Organization _____
_____ Services _____

_____

_____

_____

_____

_____

Formal Health Care Services Provided by:

General Practitioner (s)_____ Community Health Centre_____

Hospital Outpatient or Specialty clinic_____OTHER_____

Health Nurse(s)/ Health Visitors

_____

_____

Other Practitioners (including professionals in complementary therapy i.e. acupuncture. Tai Chi master, chiropractor)

_____

APPENDIX 6 LETTER OF INTRODUCTION TO AGENCIES

DATE

EXECUTIVE DIRECTOR OR DESIGNATE
AGENCY
STREET
BOROUGH
POSTAL CODE

RE: RESEARCH STUDY:
MANAGEMENT OF HEALTH AND ILLNESS IN THE FAMILY:
PERSPECTIVES OF FIRST GENERATION WOMEN AND THEIR DAUGHTERS

DEAR MR./MS./MRS. NAME OF EXECUTIVE DIRECTOR

I AM WRITING TO THANK YOU FOR AGREEING TO MEET WITH ME TO FURTHER DISCUSS THIS STUDY AND FOR SHARING INFORMATION ABOUT YOUR ORGANIZATION WITH ME. AS I MENTIONED WHEN WE SPOKE I AM A NURSE AND A FACULTY MEMBER AT THE UNIVERSITY OF BRITISH COLUMBIA SCHOOL OF NURSING IN VANCOUVER, CANADA. I AM CURRENTLY PURSUING DOCTORAL STUDIES AT KING'S COLLEGE LONDON. MY CURRENT INTERESTS HAVE DEVELOPED FROM RESEARCH AND NURSING PRACTICE I HAVE BEEN INVOLVED IN IN CANADA.

I HAVE, FOR A NUMBER OF YEARS, BEEN INVOLVED IN WORKING WITH NEW IMMIGRANTS TO CANADA. THIS WORK HAS DEMONSTRATED THE IMPORTANT ROLE OF THE INFORMAL COMMUNITY IN ASSISTING WITH THE PROCESS OF SETTLEMENT BUT ALSO AS A VALUABLE RESOURCE FOR ONGOING MANAGEMENT OF HEALTH AND ILLNESS. MORE RECENTLY MY WORK HAS BEEN WITH FAMILIES WITH ADOLESCENTS. WHILE MOST FAMILIES FIND ADOLESCENCE A CHALLENGING TIME MANY FIRST GENERATION IMMIGRANT FAMILIES FIND IT PARTICULARLY DIFFICULT TO KNOW HOW TO SUPPORT THEIR CHILDREN AS THIS SECOND GENERATION IS EFFECTIVELY NEGOTIATING BETWEEN TWO WORLDS OR CULTURES. AS

NURSES IT IS IMPORTANT WE UNDERSTAND THE ISSUES COMMUNITY MEMBERS FACE IF WE ARE TO BE EFFECTIVE IN OUR WORK IN HEALTH PROMOTION AND ILLNESS MANAGEMENT.

I APPRECIATE YOUR INTEREST IN HELPING ME TO UNDERTAKE MY RESEARCH. I ANTICIPATE I WILL BEGIN INTERVIEWING WOMEN IN LONDON IN LATE FEBRUARY OR EARLY MARCH. I WILL BE IN TOUCH WITH YOU IN DECEMBER TO DISCUSS POSSIBLE DATES. IN THE MEANTIME HOWEVER, I THOUGHT I WOULD PROVIDE YOU WITH AN OVERVIEW OF THE GENERAL PURPOSES OF THE RESEARCH, DESCRIBE THE WOMEN I WOULD LIKE TO INTERVIEW AND OUTLINE THE NATURE OF THEIR INVOLVEMENT.

AS INDICATED BY THE TITLE, THE OVERRIDING PURPOSE OF THE STUDY IS TO EXPLORE THE WAYS WOMEN DRAW UPON RELATIONSHIPS TO MANAGE FAMILY HEALTH AND ILLNESS. I HAVE A PARTICULAR INTEREST IN EXPLORING HOW FIRST GENERATION IMMIGRANT WOMEN, WITH ADOLESCENT DAUGHTERS, DRAW UPON THE RESOURCES OF THE COMMUNITY, PARTICULARLY THEIR INFORMAL NETWORK(S). FOR INFORMATION AND SUPPORT TO MANAGE FAMILY HEALTH AND ILLNESS.

I WOULD THEREFORE LIKE TO INTERVIEW 5-7

- FIRST GENERATION IMMIGRANT WOMEN
- WITH DAUGHTERS AGED 11 TO 15
- PREFERABLY WOMEN WITH SOME ABILITY IN SPOKEN ENGLISH

THE NATURE OF THEIR INVOLVEMENT WOULD BE:

- A SMALL GROUP DISCUSSION WITH THE WOMEN - AT YOUR CENTRE
  - APPROXIMATELY 1-1.5 HRS
  - I WILL PROVIDE REFRESHMENTS AND AN HONORARIUM AS DESCRIBED IN THE CONSENT LETTER ENCLOSED

- FOLLOW UP INDIVIDUAL INTERVIEWS WITH WOMEN IN THEIR HOMES - APPROXIMATELY 1 HOUR
  - SCHEDULED AT THE CONVENIENCE OF THE WOMEN

- INTERVIEWS WITH DAUGHTERS IN THEIR HOMES
  - APPROXIMATELY 30 MINUTES

THE DISCUSSIONS WILL EXPLORE TOPICS LIKE THE FOLLOWING:

- THE WOMEN'S APPROACHES TO ESTABLISHING A NETWORK OF SUPPORT IN THE COMMUNITY

- THE ROLES PLAYED BY FAMILY, FRIENDS, CULTURAL COMMUNITY ETC. IN PROVIDING HEALTH RELATED INFORMATION AND SUPPORT TO THE WOMEN AND THEIR DAUGHTERS
- DIFFICULTIES THEY HAVE FACED OR ARE FACING IN ACCESSING RESOURCES OF THE FORMAL HEALTH CARE SYSTEM
- APPROACHES THEY HAVE USED TO OVERCOME SUCH DIFFICULTIES

WHEN WE LAST SPOKE YOU OFFERED TO ASSIST ME IN IDENTIFYING A PERSON TO ASSIST WITH TRANSLATION IN THE SMALL GROUP DISCUSSION SHOULD THIS BE REQUIRED. WE SHOULD DISCUSS WHETHER THIS WILL BE NEEDED WHEN WE MEET. WE SHOULD ALSO DISCUSS SOME FORM OF COMPENSATION FOR YOU OR THE CENTRE TO THANK YOU FOR ASSISTING ME WITH THIS STUDY.

I WILL BE APPLYING FOR ETHICS APPROVAL TO UNDERTAKE THE STUDY. I REQUIRE A LETTER FROM YOUR ORGANIZATION INDICATING YOUR INTEREST IN HELPING ME WITH THE STUDY. YOU MAY SEND THE LETTER TO ME AT KING'S.

I ENCLOSE

- AN OUTLINE OF THE STUDY PROCEDURES AND CRITERIA FOR PARTICIPATION AND
- A COPY OF THE CONSENT FORM WHICH I AM HAVING TRANSLATED.

IF YOU HAVE QUESTIONS PLEASE FEEL FREE TO CONTACT ME. I CAN BE REACHED

BY EMAIL: MARY.LYNAM@KCL.AC.UK ,

BY POST: ADDRESS

OR, CARE OF MY SUPERVISOR AT KING'S.

PROFESSOR SARAH COWLEY, TELEPHONE: 0171 872 3030

ONCE AGAIN THANK YOU FOR YOUR ASSISTANCE AND I LOOK FORWARD TO MEETING WITH YOU.

YOURS VERY SINCERELY,

M. JUDITH LYNAM

Appendix 7 Descriptive Code Categories - Oct 20 – 2000 Version

- 1) Migration Experience
  - story of migration
    - years in Britain/Canada
    - language competencies
      - speaking English
      - learning English
    - pattern of migration
    - precipitating event(s)
    - influences on choice of country
    - life in Britain/Canada
      - resources for migration
      - housing
      - work
        - paid
        - unpaid
- 2) Perspectives on Migration
  - teen viewpoint on migration
    - vulnerabilities associated with migration
    - opportunities associated with migration
  - parental viewpoint on migration
    - vulnerabilities associated with migration
    - opportunities associated with migration
    - time in UK/Canada
- 3) Research process
  - reciprocity
  - teen expessing interest in research
  - gaining entry to the field
  - introducing study
  - Joint Interview process
    - mother presenting viewpoint
    - taking opportunity to 'tell'
    - researcher role
    - seeking affirmation
    - teen response & viewpoint
- 4) Participants Gaining access to community
  - Teens' connections with community
    - school
    - church
    - ethnocultural communities
      - 'Asian' people
      - 'Latin' people
        - extended family role in establishing community connections
    - Teens' extracurricular interests
      - Structured
        - community/school
          - sport - badminton/basketball/swimming/
          - music - piano/flute
        - work
          - paid
          - volunteer
      - Unstructured
        - social time
        - peer
        - adult/youth
- 5) Approaches to learning Brit/Cdn culture
  - Perspectives on Western viewpoint
  - Perspectives on own traditional viewpoint
  - Engaging with broader community (see 4/6)
  - Maintaining links with EC community (see 4/6)

- 6) Role of Informal Community
  - source of support
  - source of information
  - source of connection
  - Fostering connection (Approaches to)

    Within family
      - Mothers' connections with family
        - origin
          - seeking connection
          - resisting
        - extended family

- mother seeking connection
- mother resisting

- Teens' connections with family
  - origin
  - seeking connection
  - resisting
- extended family

Within community – creating community

- in 'church' · system of meaning
- voluntary organization
- through roles (children/parent·school etc.)
- other

- **7) Family Identity**
  - Articulating Family Values
    - Family in relation to...
      - Broader community
      - Extended family
        - Intergenerational relationships
        - Strained or severed relationships
      - Neighbourhood
    - Family as 'different' from...
    - Nature of differences
      - Family cnx vs community cnx
      - Activities of importance
      - Responding to differences
        - Accomodating
        - Resisting
    - Time vs Money
    - Gender
      - Mediated roles
        - Women & men's access to work
        - Women's involvement in family life
      - Competing commitments –family·work
        - Two parent families
        - Single parent families
      - As a basis for assigning social standing
      - Single mothers & challenges of role(s)
        - Teens supporting
        - Financial challenges of single mo. Role
      - Societal views of women
        - Of immigrant women
        - Of immigrant teens
  - Mothers View
    - Mothers' Perspectives on Teen
      - concerns re teen
        - re: teen's network
        - re teen's school performance
        - re 'community' treatment of teen(s)
      - pride in teen's behaviour

    Concerns re: family

    - Parenting
      - redefining parenting
      - uncertainties of parenting
      - characterized as a 'new' experience
      - constraints on role
      - approaches to 're'learning parenting role
    - being parent
      - setting boundaries
      - guiding
      - challenging teen
      - offering support
      - advocating
      - seeking to protect / ensure safety
      - establishing relationships with ..(see
    - Parenting resources drawn upon
      - Formal
      - informal
    - Mother's perspective of /reflections on self
      - self as old fashioned
      - questioning self 'good' parent?
      -
  - Teen perspective
    - on own social values

- teen defining self in relation to family values
    - teen in relation to family
    - teen in relation to community (peers etc.)
    - identifying differences
        - redefining self in relation...
- teen's responses to mothers' concerns
    - challenging parental view
    - challenging parental lack of trust
    - resistance
- teen's dilemmas

- **8) Safety – Vulnerability**
    - threats to physical safety
        - prior to migration
            - nature of threat
                - bombing/murder/jail
                - poverty/hunger
                - occupational hazards
        - post migration
            - nature of threat
                - bullying
                - violence/beating/rape
                - theft /vandalism
                - other
            - strategies for coping/help seeking
                - formal
                - informal
    - threats to emotional safety
        - prior to migration
            - nature of threat
                - shame
                - isolation
                - threats of violence/terror
        - post migration
            - nature of threat
                - racism
                - exclusion
                - bullying
            - helpseeking practices
            - resources for coping
                - formal
                - informal

- **9) Defining Health**
    - self as health care professional
        - in Britain/Canada
        - in home country
    - individual health status
        - self as healthy
        - self as ill
        - mental health concerns
    - health of family members
        - mental health (see also 9)
            - impact of migration on m.health
            - other events & mental health
            - coping with mental illness
                - involvement with others (see 6)
                - perspectives on community involvement in prevention
        - experiences with acute illness
            - access to health care services
            - management of acute illness
        - experiences of chronic /ongoing illness
            - access to health services
            - approaches to managing illness
                - formal resources
                    - treatment programme & funding
                    - hospital/clinic/
                    - other (disability)
                - informal resources
                    - alternative therapies
                    - managing symptoms on own
                    - drawing upon own expertise
                - illness competes with family/work life
                - taking care of own health
                - alternative perspectives on health services organization

                - involvement with hcservices
                    - in Britain/Canada
                    - in home country
                - Role of community in health services
                - Role of voluntary organizations in health services
            - knowledge of health resources
                - knowledge of illnesses of 'west'
                -
- developmental stages & health
    - use of health resources @ diff dev stages (see also 7 & 8)
        - teens
        - infants/children
        - elderly
    - nature of adolescent health concerns (also see 10)
        - health promotion/prevention
            - strategies used
            - knowledge of formal resources
        - acute illness/violence/safety (also see 8)
            - parental views
            - teen's views
- 10) Marginalization (Processes of)
    - evidence of marginalization
    - observing /experiencing injustice
        - mother's experience of
        - teen's experience of
    - impact of
        - feeling excluded from /constraints on access to ..formal
            - workplace(s)
            - housing/neighbourhoods
            - schools/
        - feeling excluded from/constraints on participation in...informal
            - play groups/peer groups/social groups
            - within neighbourhood
    - being co-opted – accepting the message
        - questioning self/redefining self as other
    - resisting marginalization
        - what is done
            - playing by the rules
            - seeking credentials
            - challenging
            - 'passing'
            - becoming part of a group
        - what is felt
            - alone
            - different
            - not as valued/equal
    - Individual's perspectives on responding – 'Enacting agency'
        - confronting racism
        - advocating for another
        - seeking justice
            - for self
            - for another
        - mobilizing support
            - informal
                - family backing
                - friends understanding
            - formal
                - institutional backing
                - knowing 'rights'
        - impediments to enacting agency
            - no institutional support
            - no family/interpersonal support
            - no awareness of how 'it' works
            - lack of resources within family
            - seeing self as of little value
- 11) Teen's perspectives on the family
    - their role in family
        - teen as resource
            - family advocate
            - childcare
            - translator/interpreter
            - family's 'hope' for the future
        - teen as 'problem'/worry

- teen alienation in family
- teen plea for more power more say in family

- **12) Teen's sources of support**
  - expectations of parental support
    - nature of support
      - material
      - affirmation
      - emotional
        - understanding or not
  - extended family
    - nature of support/gaps in expected support
    - doing without extended family
  - peers as sources of support
  - formal system (nature of support·or not) (see also 4,6 & 9)
    - material
    - practical
    - affirmation
      - schools · who within school
        - programmes within school
      - voluntary organizations
        - nature of..programmes
- **13) Views of Teens · resources or social pariahs**
  - teens
    - immigrant teens
      - special needs/vulnerabilities/challenges
      - defining place
    - teen's views of teen's
      - teens as sources of support
      - teens as oppressors/bullies/threats
      - teens as source of information
        - facilitating access to new contexts
  - teens as problems
    - teens as threats to community safety
    - teens as expensive/social drain
  - as family advocate or resource
  - future of society
    - valuable investment?
      - nature of programmes or resources for ..
      - lack of programmes or resources for...
  - as consumers
  - as resources
    - involvement in voluntary organizations
    - contributions to community /peers/schools
- **14) Constructing difference**
  - Family as a context for defining difference
    - layers of difference
    - perceive selves as outside · other life
  - education as a way out/way in
  - cultural interface
  - Constructing teenager
    - parental viewpoints
      - setting boundaries
      - setting parameters on social network/act
  - teen viewpoints
    - defining activities
    - challenging parameters of social network/act
    - goals
    - on school
      - school as a site of inclusion·exclusion
      - school relationships
        - peers
        - teachers
        - others
      - capacity building
        - academic
        - extracurricular opportunities
- **15) Constructing culture**
  - ethnoculture
  - family vs community
  - parental versus teen culture
    - two world views
    - 'old' vs 'new'
- **16) Teens viewpoint on parental relationships**

- plea for privacy
- plea for support
  - seeking affirmation
- perspective on parental viewpoint
- seeking engagement
- characterizing as 'old' & out of touch

- **17) Reflections -Regrets**
  - reflecting on parental style & outcomes
  - reflecting on country-context as threat
  - do benefits of migration outweigh the losses?
  - parental dilemma how to protect?
    - Do/did we have a choice?
    - How can re re-create family /community life here?
    - What could I have done differently?
    - Are 'they' right?
- **18) Work roles**
    - Mothers
      - Paid/unpaid
    - Fathers
      - Paid/unpaid
    - Teens
      - Paid/unpaid
  - Characterized by
    - downward mobility
    - (lack of) recognition of credentials?
    - timing/location of work
    - pay
    - part time/full time
    - temporary/permanent
  - Gaining entry to workforce
    - Mediated by Ethno-c-community cnx
    - Use of formal resources
    - other
- **19) Helpseeking**
  - mothers
    - formal
    - informal
  - teens
    - formal
    - informal
  - gaps in service
- **20) Role of community**
  - transmission of knowledge
  - gain access to informal system
  - context for affirmation
- **21) Voluntary organization**
  - type
  - role
  - structure
- **22) Impact of environment**
  - on day to day life
  - housing
  - costs - fuel/r/electricity/telephone/transportation
  - safety
  - sense of community/neighbourhood vs feelings of vulnerability/no safety
- **23) Financial Material Resources**
  - money as a source of conflict/tension/ worry
  - financial hardship
    - limited money for basic needs
      - transportation challenges
      - creates uncertainty in housing/day to day
      - housing substandard/inadequate
        - no heat/leaking/poorly maintained
    - draw upon 'charity'
      - food bank/church/
    - availability of formal resources
      - housing
      - co-operatives
      - school lunch programmes
      - subsidized activities available to children
  - managing on work income
    - housing affordable & adequate
    - funds for recreation/leisure
  - sources/nature of income

        - # family members working
- 24) Health Care System
    - appraisal of hcsystem
        - perspectives of illness care
            - accessible, available
            - comparisons with home country
    - approaches to helpseeking
        - barriers to access
            - translation/intepretation
            - impact of changing neighbourhood
        - views on health promotion /screening
        - views on school health services
        - views on mental health services
            - traditional & alternative
            - impact of migration on
    - community participation in health care services
- 25) Family
    - structure
    - membership
    - household
- 26) Demographic data
    - data in interview for demo data form

Appendix 8 Theoretical Memos Sample

Theoretical Memo July 27/2000

Process as structure...that is, thinking about the place of reflection, subjectivity etc.
One exemplar could perhaps be images of structure....as barriers or constraints.
May be able also to illustrate process (as a structural constraint) as a mechanism that creates or mitigates barriers. (physical or otherwise).
For example, if we look at the face of the demographic data or family profiles we see similar descriptive structures, but if we examine the processes, the relationships with persons outside of that structure...the message that people see them differently, or people have created opportunities for them ..these emerge as processes that make a difference.

Theoretical Memo August 1/ 2000

Thinking about the relationship of this PhD work to other work. *Locating the family (parent adolescent sub unit) in the context of the community - as informal system.*

Thinking about the broader question of how do 'social determinants' like *marginalization, racialization, poverty ... exert their effect?*

Evidences of structural..exclusion i.e. cost/affordability/access to activities-safe neighbourhood, schools etc.

Evidences of social exclusion i.e. not being able to participate, dress,

Evidences of mitigating social exclusion,,,,being able to 'pass'
for some (who?---) the experience is different because they feel both that they are safer and in a better place subsequent to migration, their country of origin did not hold the possibility of a future for themselves or their family.....

Questions to ask of the data -
? what characterizes a sense of belonging?
? what mitigates sense of marginality?

Patterns to examine in the data.....
For parents
Do data suggest... a sense of social purpose?
Being part of an organization
Connections that enable them to see themselves as not alone with the issues they are facing...
for some advocacy organizations.....
one parent in particular excluded...see data related to not getting respect etc.
daughter able to extend beyond..accept her mother and her situation and also connect outside

For teens:
being part of social scene
getting recognition for abilities...having abilities, contributions be be socially valued?
does it look different if the social value is that of teens/youth/popular culture versus adults/parents/etc.
engaging in joint activities....

EXAMINE – CONSIDER...
What insights does social capital (habitus) capacity building offer to these analyses?

What insights does a post colonial analysis - power, oppression, resistance offer to these analyses?

What insights does an emancipatory analysis - resistance, insight, fostering agency offer to this analysis?